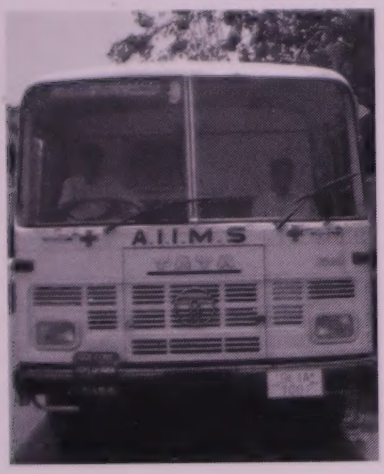
Health of the Urban Poor and Role of Private Practitioners

The Case of a Slum in Delhi



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In collaboration with
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2009

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Acronyms and Abbreviations

AIDS	:	Acquired Immune Deficiency Syndrome
AIIMS	:	All India Institute of Medical Sciences
CCM	:	Centre for Community Medicine
BP	:	Blood Pressure
Danida	:	Danish International Development Assistance
DOTS	:	Directly Observed Treatment, Short Course
ENT	:	Ear Nose Throat
FFU	:	Consultative Research Committee for Development Research
GOI	:	Government of India
HIV	:	Human Immunodeficiency Virus
ICCIDD	:	International Council for the Control of Iodine Deficiency Disorders
MBBS	:	Bachelor of Medicine, Bachelor of Surgery (Latin - Medicinae Baccalaureus, Baccalaureus Chirurgiae)
MoHFW	:	Ministry of Health and Family Welfare
NGO	:	Non-governmental organization
TB	:	Tuberculosis
UHRC	:	Urban Health Resource Centre
WHO	:	World Health Organization

HEALTH SYSTEM REFORM AND ETHICS: PRIVATE PRACTITIONERS IN POOR URBAN NEIGHBOURHOODS IN INDIA, INDONESIA AND THAILAND

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Executive Summary

The Project

The project *Health Systems Reform and Ethics: Private Practitioners in Poor Urban Neighbourhoods in India, Indonesia and Thailand* is a multi-disciplinary multi-country research study on the private health sector in urban poor settlements in south and south-east Asia. The study was carried out simultaneously by Aarhus University, Denmark, All India Institute of Medical Sciences (India), Naresuan University (Thailand) and Gadjah Mada University (Indonesia) and funded by Danida's research council, Consultative Research Committee for Development Research (FFU), Denmark.

The main objective of the project was to identify feasible regulatory mechanisms and strategies for the private healthcare sector to improve quality of care, including for the urban poor in India, Indonesia and Thailand. The specific objectives were: (a) to identify systematic constraints in private practice with negative consequences for healthcare, in particular pertaining to treatable infectious diseases; (b) to determine constraints for practitioners' and poor patients' treatment-related decision-making; and (c) to identify similarities and differences through comparison of data and findings across centres within and outside the project and describe their health policy implications. The project consisted of four sub-studies, which complemented each other in order to give a detailed and multi-faceted understanding of the local health systems under study. *Sub-study 1* was a desk study of existing regulatory mechanisms, including ethical codes and legislation with direct implications for general private practitioners; *sub-study 2* an ethnographic study of health systems ethics among private practitioners; *sub-study 3* an interview-based study of family level treatment decision making; and *sub-study 4* a survey of health expenditure patterns at the household level.

This report presents the findings of the research (in particular sub-studies 1, 2 and 3) carried out in Delhi during April 2004 – March 2008 by the Centre for Community Medicine, All India Institute of Medical Sciences, New Delhi.

The urban poor and the private health sector

The burgeoning 80 million urban poor in India struggle for basic services like housing, water and sanitation. The links between these contextual forces and health outcomes is manifest not only in the striking differentials in health among urban poor and non-poor groups but in health indicators of the urban poor which are comparable to, and in many cases, worse off than, the poor living in rural areas of the country. Despite the presence of a vast public health network, in the absence of urban primary health care services, the private sector assumes prominence in the health seeking behaviour of this sub-population. One of the largest private healthcare sectors in the world, it encompasses a wide range of players. The private sector that the poor access may be thought of consisting of three wings: (i) the fully-organized-and-fully-qualified; (ii) the fully qualified private providers that operate in less than well to do neighbourhoods where the slum population too go; and (iii) the 'less-than-fully-qualified' practitioners in the slum. The last group comprises practitioners who are either untrained or minimally trained in any system of medicine or trained in one system and practise another. It is estimated that these untrained, unlicensed practitioners in the country outnumber qualified medical doctors by at least 10:1. Although a large majority of them operate in rural areas, urban areas too are witnessing increasing numbers of these untrained practitioners as we see in the report.

Private practitioners use treatment strategies that are not only unsuitable but often dangerous. The absence of a nation-wide focus on the private health sector is responsible for the lack of a clear and integrated legislative framework. Despite the existence of laws

in the country, many of them are out-dated, not adequate enough and those that are adequate are not enforced properly. Issues like cross practice and degrees granted by obscure institutions which are not recognized by the states are relatively uncomplicated but issues regarding medical negligence, for instance, are difficult to prove. Lack of awareness among the people, either regarding the existence of these laws or of the measures to seek redressal, is the main reason why many cases of malpractice, especially in the private sector, are not filed. Circuitous procedures and excessive time taken to reach judgements in the courts act as major deterrents to seek judicial action. The rapid expansion of the private sector in this unregulated environment with no mechanism for standardization of care thus emerges as a matter of pressing concern.

The case of Midanpuri in Delhi

Nearly half of Delhi, one of the richest regions in the country, lives in poor habitations. Despite the ambiguity that persists regarding the actual size of the urban poor population in the city, the abysmal critical health indicators among them indicate the multiple vulnerabilities that they face. Neo-natal mortality rate, infant mortality rate, and child mortality rate among the urban poor in the city are among the highest in the country. There are several outbreaks of preventable diseases. Only 25% are fully immunized by age one year. There is high anaemia prevalence and nearly half of the urban poor children are malnourished and face an increased burden of diseases such as measles, diarrhoea, diphtheria, whooping cough and tetanus. Ante-natal coverage is low. Only one-third of the pregnant women receive three or more antenatal check-ups. Total fertility rate is high. Malaria prevalence is more than double that of urban high-income groups and tuberculosis prevalence is more than double that of the urban average. Despite the presence of large number of hospitals and health facilities in the city, there exists a burgeoning private health sector. While many of these private facilities are beyond the reach of the poor, individual

practitioners, both qualified medical doctors as well as unlicensed health care providers who run clinics in and around slum settlements are often the first resort. The Indian Medical Association estimates that there are 40,000 unregistered medical practitioners in the city who are not trained in any system of medicine, and that there are two 'quacks' for every registered medical practitioner.

Midanpuri in Delhi is a slum settlement that was selected for this study to explore the dynamics of the private health sector among the urban poor. Located in south Delhi near one of the city's most affluent neighbourhoods, it has an estimated population size of around 25-30,000, and is composed almost entirely of migrants from neighbouring villages and from the states of Uttar Pradesh, Rajasthan, Bihar, Haryana, Madhya Pradesh, Uttaranchal, Kerala, Karnataka and Andhra Pradesh. There are 27 private clinics run by 'less-than-fully-qualified' health care providers in the slum. There is no government health centre with the two closest dispensaries being located approximately three kilometres away.

Fieldwork for the study was conducted over a two-year period from June 2004 to May 2006. A total of 25 private practitioners were enrolled for the study, 18 practitioners located in the slum, and 7 private practitioners located in markets within a 3-4 kilometre radius from the settlement. From a total of 207 households enrolled to track household expenditure on health (sub-study 4), 25 households were selected for in-depth case studies to explore the families' treatment seeking behaviour and, in particular, to examine decision-making processes and reasons for choice between private and public health services. A combination of ethnographic methods was deployed to generate data for both sub-studies.

Treatment seeking behaviour

High alcohol consumption, drug use, extensive use of *gutka*, powdered tobacco, and sedatives were recorded. A large number

of mental conditions, many of them undiagnosed, were also reported by the respondents. Although the women were reluctant to talk about domestic violence, almost half of them were found to be victims of physical violence. At least one member from the 25 households was found to visit a health care provider once every five days. While there is no slum specific data on morbidity, every household we interviewed reported at least two illnesses most of which could be classified as acute respiratory problems and water borne diseases. During the summer months there was a surge in epidemic prone infections. In all, 31 chronic conditions were reported from the 25 households (on the basis of a classification of a chronic condition as one lasting three months or more). Although there was general awareness about sexually transmitted diseases and HIV/AIDS, knowledge regarding its methods of transmission was very poor. Despite the availability of institutional delivery services in the city, 38% deliveries were reported to have taken place in hospitals relative to the majority that delivered at home with the help of traditional birth attendants.

There was an almost exclusive dependence on the less-than-fully-qualified practitioners within the *jhuggi* for treatment of "everyday illness conditions" like cold, cough, fevers, headache, joint pains, and minor injuries. For conditions which required "further treatment", qualified private practitioners in the neighbouring areas were consulted. During the two years of fieldwork, only two cases were reported of visits to a government dispensary. The need to commute to the dispensary, the long waiting time and the lack of medicines in the dispensary were cited as deterrents to visit the dispensary. There was little mention of traditional healers; the only exceptions being for male sexual health and mental illness.

We found that the respondents in most cases looked for basic care. In all cases, there was a single-minded focus on getting immediate 'action' with a purpose to return to work as quickly as possible. The decision to seek medical care was seldom guided by

the perceived cause of illness. Rather, it was always a pragmatic decision to deal with the condition effectively enough to return to work as quickly as possible with the available resources in hand at that time. The role of 'cultural factors', therefore, was found to be minimal. Access was found to be the major determinant of health seeking behaviour. Physical access (distance to the clinic, availability of the practitioner and ready dispensation of drugs) was cited as the most important factor. Social access came a close second. The low fees and the flexible payment options offered by the neighbourhood practitioners were considered extremely convenient for wage earners. The cost of consulting a neighbourhood practitioner at Rs 35 per visit, compared favourably to not only qualified private practitioners but even government-run facilities. While consultation with a doctor in a government facility was free, transportation and more importantly, purchase of medicines from pharmacies drove costs to an average of Rs 68 per visit, which was almost twice that of a less-than-fully-qualified practitioner. Often, additional costs were inflicted when circuitous procedures and long queues in the hospitals resulted in losing the day's wages.

Quality of care figured prominently in patient narratives. Private practitioners were considered to "give more attention" in comparison to the government facilities which were too slow and "difficult to deal with". Besides, the ready dispensation of medicines and administration of injections (often on demand) qualified as "better care". Predominant in patient narratives, across gender, was dissatisfaction with treatment received for much of their health conditions. In a majority of cases, this could perhaps be linked to the irregularity of treatment. In two-thirds of the 92 illness trajectories that were documented in detail, practitioners were changed more than four times. Despite cost being one of the main determinants in choosing a treatment provider, a large number of people in fact said that they were willing to pay for higher quality care which, as they would lament time and again, was neither accessible nor available to them.

Why not the free public sector?

Competence in government facilities was clearly considered higher by the respondents but long distances to these facilities, circuitous and time-consuming registration procedures, and waiting time were cited as major deterrents. Narratives of care seeking for stigmatized conditions were replete with the need for privacy and sensitivity that the private practitioners offered. In contrast, experiential accounts of government facilities were dominated by a total lack of concern by the non-medical staff; senior doctors who were not approachable and the younger, inexperienced doctors who were brusque and did not listen to what the patient had to say. Several respondents recounted how they had to pay bribes to staff in government hospitals to get ahead in the waiting line. In contrast, positive responses to service received from the private health care providers were tied to clinic opening times, fees, waiting times, and accessibility of the practitioners. Under the circumstances, there was an unambiguous preference for "better care" by the neighbourhood practitioners, who might be less-than-fully-qualified, in comparison to inadequate care in a government facility. Government hospitals, however, were cited as the main option in connection with conditions which required inpatient care and surgical intervention.

The obvious benefits associated with having health care at hand propelled choice on most counts, even if the people are aware that the local practitioners might not possess the 'best' qualifications. The absence of qualified doctors in the slum was a common ground for argument in favour of the unlicensed practitioners' presence in the settlement by both themselves as well as the inhabitants of the area. In slums such as Midanpuri, where no qualified medical practitioners are available, it is not so much about exercising choice from a variety of options as it is about making do with what is available.

Health care providers in Midanpuri

During the two years of field work, the number of clinics run by less-than-fully-qualified practitioners in Midanpuri increased from 15 to 27. Only five of them had documents certifying that they were Registered Medical Practitioners; the rest were unlicensed practitioners, not registered in any system of medicine. Three-fourths were undergraduate and did not possess formal degrees and the remaining were 'trained' outside Delhi through short-term diploma courses in Ayurveda and Homeopathy. Seven of them produced certificates from institutions which are not recognized by the government. All of them, without exception, were found to administer biomedical drugs. The timings of the clinic were designed to 'fit' the work schedule of the inhabitants of the settlement. Drugs, they said, were purchased from chemists, from medical representatives and even government outlets. The latter was facilitated by staff employed in these dispensaries. There was no system of registration in the clinics of the less-than-fully-qualified practitioners and no records were maintained of the patients. Treatment was provided purely on an episodic basis. No evidence was found of either any inpatient procedures or deliveries conducted. Immunization services were also not provided. Referrals to abortion clinics on demand, however, were very common. Almost all the practitioners we interviewed spoke of aspirations to "become better doctors". They evinced an eagerness to participate in workshops and be part of national programmes run by the government. The research team was constantly asked, particularly towards the end of the project, whether they would assist in training them, or in acquiring higher skills.

Clinical interactions

Of the 471 clinical interactions recorded during observations in the clinics of both groups of private practitioners, three-fourths were acute conditions, predominantly fever (of indeterminate origin),

cold, diarrhoea, asthma, cough, body pain, weakness, tuberculosis, skin problems, mental problems, sexually-transmitted diseases, injuries, and conditions reported as 'BP' (blood pressure). A striking number of abortions as well as many cases of repeated surgery after abortions were also recorded.

The interactions with the practitioner were usually short with the average consultation lasting no more than 3-5 minutes. There was an almost exclusive focus on curative care and 'what the patient wants'. Perceived strictly as a business, these practitioners seemed to have an exacting assessment of the prevailing market forces, and delivered accordingly. If patient interest centred around medication, the focus was explicitly on the medicines alone but in cases where attendant causes of illness were sought, references to diet and the environment were offered by the practitioner. The atmosphere in the clinics was invariably relaxed. Continuing conversation with other patients waiting to be seen or with the companion accompanying the patient was common.

Drug dispensation

Although making a prescription audit was beyond the mandate of the study, observations in the clinics of private practitioners demonstrated that there was an excessive use of antibiotics and injections. Although in approximately one-third of the cases in clinics of less-than-fully-qualified practitioners, loose medicines without a counterfoil are given which made it difficult to assess each category, it was possible to determine that these medicines were largely antibiotics, painkillers and tranquilizers. The injections were largely administered with corticosteroids. Several instances of reuse of disposable injections by the less-than-fully-qualified practitioners were recorded.

Virtually all prescriptions in the 471 clinical interactions with both groups of practitioners had multi-drug combinations, the most

common combination of drugs being antibiotics, analgesics and multivitamins. While injections for pain, tranquilisers, multi-vitamins and pain killers were the main choice among the less-than-fully-qualified practitioners, antibiotics emerged as the most common category of medicine among qualified private practitioners. Of the 37 prescriptions recorded in the qualified private practitioners' clinic, 32 prescriptions contained at least one antibiotic. While both categories used anti-tuberculosis drugs, none of them observed the Directly Observed Treatment, Short Course strategy. None of the less-than-fully-qualified practitioners had any knowledge of the national tuberculosis control guidelines while the qualified private practitioners said that they did know of the guidelines but "did not have the time" to "follow" them.

In the clinics of the less-than-fully-qualified practitioners, direct request for medicines for specific ailments was found to be common.The practitioners in turn gave clear instructions on how to "take the tablets". Loose medicines were explained in detail according to colour, size and shape and doses are prepared into *pudiyas* (small individual paper packets). Generic descriptions were provided with medicines being specified as "for heart", "for bones", "for tension", "for sadness", "for BP". Doses were given according to the amount of money in hand; if money was not cited by the patient as a constraint, doses would be given for two days at a time. The sale of partial doses of medicine in particular was cited as a huge boon by a majority of patients who were dependent on daily wages.

It was noted that the neighbourhood practitioners often received patients who had already consulted other qualified medical practitioners and visited them for follow up consultations. It was common practice for these practitioners to scrutinize prescriptions given by the qualified practitioners and dispense the same set of medicines. Many of them retained these prescriptions and administered the same cocktail of drugs to other patients who reported similar symptoms.

Less-than-fully-qualified vs. fully qualified practitioners

The payment system was different for the two categories of private practitioners. While the qualified private practitioner charged a flat fee of around Rs 50, the less-than-fully-qualified private practitioner's payment system was flexible and ranged between Rs 20-40, depending on the amount of tablets or injections administered. The less-than-fully-qualified practitioners insisted that there was no consultation fee and they charged only for the medicines. The reality, however, was that the consolidated amount of money that was charged includes consultation as well as the medicines. Notwithstanding the actual breakup, fee levels were kept low but ensured that there was some profit after paying for capital costs.

Despite the small number of qualified practitioners in comparison with the larger group of less-than-fully-qualified practitioners, an attempt was made to compare prescription practices among both groups. This would, therefore, serve more as an interim observation rather than a conclusive one. In a comparison of prescriptive behaviour patterns between the two groups for fevers (undetermined), cough and cold, diarrhoea, vaginal discharge and tuberculosis, the difference on first consultation was found to be marginal. The only major difference was that among the former, a prescription was written out and a flat consultation fee was charged while the latter group dispensed medicines and charged a variable fee that included consultation as well as medicines administered by the practitioner. Other parameters that were taken into consideration while comparing the two groups of practitioners include duration of consultation, number of questions asked, physical examination of the patient, referrals to both public and private facilities, and attribution of competence by the patient and/or caregiver. A final variable that was used from the initial days of observation of the practitioners was the level of variation, if any, in the practitioner's knowledge (as recorded during

interviews) vis-à-vis his practice in the clinic (as recorded during observations of clinical interactions). While large discrepancies between what they knew and what was actually observed in the clinics was found in both groups of practitioners, the variation seemed to be larger among the group of qualified practitioners studied.

Referrals to diagnostic facilities for X-rays and blood testing were common in both groups. However, while networks between the qualified practitioners and diagnostic facilities in neighbouring Munirka and Mahipalpur were clearly discerned, this was not the case among the less-than-fully-qualified practitioners. There were very few referrals to other (qualified/ medical) doctors among both groups. Referrals to government-run hospitals were more marked among less-than-fully-qualified practitioners than among the qualified private practitioners. However, most of these referrals were made in acute conditions after at least 4-5 visits to the practitioner. In a majority of the cases, the conditions seem to have deteriorated significantly by the time the referrals were made.

Which way forward?

Choices that the urban poor make for health care have implications not only for the individuals treated and the development of drug resistance but also for disease transmission to the wider population living in congested urban settings. While their recourse to less-than-fully-qualified practitioners is of urgent concern, their recurrent use of qualified private practitioners too needs attention. While the public health consequences of the inappropriate treatment protocols that the less-than-fully-qualified private practitioners use, and their misuse of drugs, is well known, arbitrary prescription practices and delayed referrals to appropriate facilities by qualified private doctors pose potential threats as well. Unlicensed practitioners very often are the only ones 'on the spot' to provide basic primary care to the approximately 25,000 people inhabiting

slum settlements such as Midanpuri. Their piecemeal medication options are a boon for daily-wage earners; they seem aware of health epidemics and media campaigns around conditions like HIV/AIDS, tuberculosis and maternal care; and they clearly appear to treat patients with dignity and respect. What is evident, therefore, is that these less-than-fully-qualified practitioners fill an important gap between the poor perceived quality of public health services and the high cost of the "fully qualified" private health care. In the absence of better alternatives, what does the poor person in a slum settlement do? Under the circumstances, it could then be argued that they largely succeed in providing at least *some* health care at low cost where none other exists.

Police raids are not the answer. Local networks within the neighbourhood relayed information about imminent raids and the practitioners were often helped to 'close down' their clinics. The research team was witness to two such raids in the neighbourhood where signboards outside the clinics were hidden or pulled down and certificates with (fake) registration numbers hidden. After the raids were conducted, the practitioners 're-opened' their clinics and continued to practice from the next day. Thus, it makes more sense to find ways to involve, rather than outlaw them. Instead of policing, considerable scope exists for change both within the public sector as well as the private sector. No single strategy will work. A combination of measures would need to be put in place involving a diverse set of stakeholders.

Institutional shortcomings of the *public sector* obviously need to be urgently addressed. There should be more specific focus on more public outreach and on making this outreach more responsive. Unless the existing system is restructured to ensure that it 'works', there is no point in replicating what exists. Regulation and monitoring of the *private sector* emerges as the most pressing concern. The fully-organized-and-fully-qualified sector consisting of large network of institutions and individual providers need to be made more

accountable to the public. The legislative framework needs to be urgently revamped. While the private sector has been incorporated into the Consumer Protection Act (1986), it is unlikely to be effective on its own unless mechanisms to seek redressal are framed keeping the poor in mind. Rational *drug prescribing* is an imperative that cannot be ignored.

Since the less-than-fully-qualified practitioners appear to be the 'backbone' of providing health for the urban poor, they need to be co-opted into intervention programmes for the poor. The main challenge, however, would be to bring them into the overall public policy net. As the less-than-fully-qualified practitioners evinced enthusiasm in acquiring higher skills and in participating in government-run programmes, a system could be devised whereby a special cadre of practitioners could be trained to deliver a select range of services in difficult-to-reach populations in the slums. They could be trained to recognize and refer complicated cases to government facilities if clear definition of parameters for enrolment and standard treatment guidelines are framed to define the exact nature of their functions. Referral protocols and service delivery linkages established at all levels of care for all kinds of ailments will prevent overcrowding of public hospitals for conditions that can be treated at urban health centre level. Lessons could be drawn from the INFECTOM (INformation, performance FEedback, ConTracting, Ongoing Monitoring) strategy developed by the BASICS project to improve case management practices of private practitioners in childhood illnesses; in-service training for management of diarrhoea and acute respiratory infections by private practitioners in Mexico; and training shop-keepers to provide anti-malarial drugs in Kenya. It would be crucial, however, to maintain focus on accurately assessing training needs on an on-going basis and providing the necessary upgrading of skills.

None of the above will work effectively unless complimentary measures are enforced to confront the local context in the slums.

Provision of basic amenities like housing, security of tenure, clean drinking water, sanitation and electricity should be accorded highest priority. Income generation programmes within these slums will bring in security of income. There needs to be a concerted effort in ensuring that the various schemes within the public sector are accessed and utilized for the entire family. Slum specific interventions should begin by taking each region in a city and collecting data and analysing the health status as baseline information; all health-related services (all private practitioners, types and kinds of practice) need to be mapped and in-depth information on client satisfaction needs to be collected. Unless health facilities are responsive to the requirements of the urban poor, there will not be optimal utilization of its services and the existing ambivalence towards government institutions will continue. This could be achieved by allocation of qualified doctors in all under-served areas, perhaps through a compulsory student roster like out-patient wards in hospitals, and regular mobile clinics in slums.

If increased uptake is a policy aim, programmes must be made available and accessible. Micro-planning strategies with the help of a consultative approach involving all stakeholders - NGOs, self-help groups, private practitioners - will determine what is best in a specific context. Slum level committees (with representations from both males and females and adolescent groups) should be formed to plan, take ownership of, and monitor programmes. A monthly surveillance system will help to monitor the practices of the private practitioners that they are not providing healthcare outside their training as well as to monitor the quality of services provided in the public health facilities. Community collectives will also ensure access at the household level. Public awareness campaigns should focus on educating consumers about inappropriate treatment protocols like re-use of disposable syringes and to provide feedback to public authorities. A separate health insurance scheme or the urban poor under the National Urban Health Mission will ensure that health care payments do not exceed their ability to pay.

Coordination between various service providers such as the state health department, Urban Local Bodies, Integrated Child Development Scheme, the Swarana Jayanti Shahri Rozgar Yojna scheme for construction workers, and NGOs will ensure that work is not carried out in silos and will optimize the effectiveness of programmes.

Introduction

The project

The project *Health Systems Reform and Ethics: Private Practitioners in Poor Urban Neighbourhoods in India, Indonesia and Thailand* is a multi-disciplinary multi-country research study on the private health sector in urban poor settlements in south and south-east Asia. With Aarhus University, Denmark in the lead, the study has been carried out simultaneously by the All India Institute of Medical Sciences (India), Naresuan University (Thailand) and Gadjah Mada University (Indonesia). The project sites were located in New Delhi and Bhubaneswar (Orissa) in India, Phitsanulok in Thailand and Yogyakarta in Indonesia. The study was funded by Danida's research council, Consultative Research Committee for Development Research (FFU), Denmark.

This report presents the findings of the study carried out in Delhi.

Objectives

The main objective of the project was to identify feasible regulatory mechanisms and strategies for the private healthcare sector to improve quality of care, including for the urban poor in India, Indonesia and Thailand. The specific objectives were:

a. To identify systematic constraints in private practice with negative consequences for healthcare, in particular pertaining to treatable infectious diseases
b. To determine constraints for practitioners' and poor patients' treatment-related decision-making
c. To identify similarities and differences through comparison of data and findings across centres within and outside the project and describe their health policy implications

Sub-studies

The project has supplemented an understanding of the private practitioners' perspectives with an understanding of the patients' perspectives. The study consisted of four sub-studies, which complemented each other in order to give a detailed and multi-faceted understanding of the local health systems under study:

Sub-study 1	:	Existing regulatory mechanisms, including ethical codes and legislation with direct implications for general private practitioners: desk study
Sub-study 2	:	Health systems ethics among private practitioners: ethnographic sub-study
Sub-study 3	:	Family level treatment decision making: interview sub-study
Sub-study 4	:	Household survey: health economics sub-study

The report provides a summary of sub-studies 1, 2 and 3.

The research team

In India, the project in Delhi has been carried out by the Centre for Community Medicine, All India Institute of Medical Sciences (AIIMS), New Delhi during the period April 2004 – March 2008. The project has received due clearance from the Ethics Committee at AIIMS.

The study team comprised the following:

Dr Chandrakant S. Pandav	:	Principal Investigator
Dr Kusum Verma	:	Principal Investigator (retd.)
Dr Nupur Barua	:	Co-Principal Investigator
Dr Jenifer Lobo	:	Advisor
Dr Anita Acharya	:	Community Medicine Specialist
Mr Otojit Kshetrimayum	:	Research Assistant
Mr Birendra Suna	:	Research Assistant
Mr Kripabar Baruah	:	Research Assistant
Mr Subhas Ranjan Nayak	:	Research Assistant
Mr Mrinal Das	:	Research Assistant
Ms Yaoreiphy Horam	:	Research Assistant
Ms Malvika Maheswari	:	Research Assistant

Dissemination

As the study progressed, research findings were disseminated through various presentations in national and international meetings and conferences. Some of the presentations made by the Delhi project team have been appended to the report (see Annex 1).

International research-to-policy workshop

The partners involved in this project organised an international research-to-policy workshop in Thailand in June 2007 to disseminate findings of this project and related research in the region and to develop policy implications on the basis of this research. The workshop was attended by researchers from the four countries involved by researchers, government representatives, the World Health Organization (WHO), civil society and professional organisations from India, Indonesia and Thailand, as well as international scholars from Denmark, Norway and USA. The objectives of the workshop were: (a) to identify feasible regulatory mechanisms and strategies for the private healthcare sector to improve quality of care for the poor in urban India, Indonesia and Thailand; and (b) to identify lessons learnt and best practices from health policy interventions for the urban poor in the three countries.

Presentations covered a broad range of themes that together establish a highly relevant context for any discussion of the private health care sector in urban areas. The main issues that emerged from each country under four cross-cutting themes were health care sector and patient rights; rights, regulation and legislations; quality of services; and health financing. The full workshop report is appended to the report (see Annex 2).

National workshop

In Delhi, a national level workshop was conducted in May 2008 with participation by representatives of Government of India,

Government of Delhi, WHO, research institutions and policy makers involved in development of the National Urban Health Mission, as well as researchers from AIIMS and Aarhus, Denmark. The main objective was to discuss implications of the research findings from this project in relation to development of the proposed National Urban Health Mission in India.

The workshop report and media coverage of the meeting, in the form of clippings in the press, are appended to the report as Annex 3 and 4 respectively.

The website www.hum.au.dk/hsre provides all relevant information related to the multi-centre study.

1

Background

1.1. Public health services and the urban poor

The impact of poverty in India must be understood in the context of one of the world's most populous countries. With more than 290 million people living below the poverty line, it has been estimated that, taken together, the urban poor in India could constitute the fourteenth largest country in the world (Varma 2003). From existing studies we know that the poorest 20% of Indians have more than double the mortality rates, malnutrition and fertility of the richest quintile (Peters et al. 2002). And despite the large and multi-tiered health system of the country with an extensive network providing free primary health care, in the most populous and poorest states, the public system does not reach even a quarter of the target population (World Bank 2004).

It is by now well known that public health subsidies are found to be disproportionately distributed in favour of the rich as higher income groups benefit three times more than the poorest (Mahal, et al. 2002). With health insurance covering less than 10% of the population (World Bank 2004), the main source of health care financing is household out-of-pocket expenditure (Peters et al. 2002). While average costs for medicines, doctors' and hospital fees in private hospitals can amount to twice a family's monthly income, even using public services is costly: almost 50% of the patients spend more in a day on health care expenses in a public hospital in Mumbai than the daily income of their entire household (Iyer et al. 1996).

The situation in *urban India* is particularly grim. One-fourth of the country's staggering urban population of 285 million, estimated

to reach 534 million by 2026, lives in slums which are overcrowded, often polluted and lack basic civic amenities like clean drinking water, sanitation and health facilities. The United Nations Human Settlements Programme (2003) defines a slum as an urban area with a lack of basic services (sanitation, potable water, electricity), substandard housing, overcrowding, unhealthy and hazardous locations, insecure tenure and social exclusion. The absence of urban primary health care services in the country has led to serious public health consequences for the urban poor. Accurate health statistics in slums is difficult to obtain but under-five mortality rate among the urban poor has been found to be three times higher than that of the higher economic strata and the proportion of severely underweight children is five times higher than higher income groups. Preventable chronic diseases become complicated with delays in seeking medical care. Urban Health Posts are located too far from the highly populated and congested slum settlements and in situations where they exist, shortage of basic drugs, equipment, absence of personnel, a poorly operating referral system, and attitudes of public health functionaries pose major access barriers for the poor line who are critically dependent on these public health services.

1.2. The private sector

1.2.1. Structure

Rising inequities in provision of health care and perceived shortcomings of the public sector to deliver effective health services push people into the private medical sector which has expanded enormously since the early 1990s (Peters et al. 2002; Purohit 2001; Berman 1997). Set within the context of a supply induced demand economy, this entire sector operates on a profit basis. However, this sector is heterogeneous and both the scale of operations as well as the quality of care varies. It encompasses a wide range of players - individual private practitioners providing medical prescriptions; formal for-profit group comprising individual clinics

and nursing homes; large corporate hospital chains with world class amenities and tertiary facilities; pharmacies; and not-for-profit providers such as charitable clinics, religious facilities and non-governmental organizations (NGO). Larger private sector facilities are found in larger urban centres. The not-for-profit sector operates often through charitable initiatives. Some of these facilities, funded from user-charges or philanthropic donation, provide care in areas like HIV/AIDS counselling and run tuberculosis (TB) clinics.

The private health sector is not confined to just allopathic practitioners. There are nearly twice as many practitioners qualified in various Indian Systems of Medicine and Homoeopathy. A larger proportion of them (60%) are located in the rural and backward areas with 90% of them also practising modern medicine (Duggal 2007). Further, there is another large chunk of practitioners, estimated at about half as many as the qualified, who practise modern medicine without appropriate training in any system of medicine. Although a large majority of them are in rural and backward areas, urban areas too are witnessing increasing numbers of these untrained practitioners as we will see later in the report.

In the absence of accessible government clinics and hospitals, private health care is no longer the privilege of the rich but it is increasingly serving as the only option of the poor as well. It is not surprising, therefore, that the numbers of practitioners operating in the private sector are very large. Of the 1.4 million medical doctors in 2004, 1.2 million are estimated to be in the private sector (ibid.).

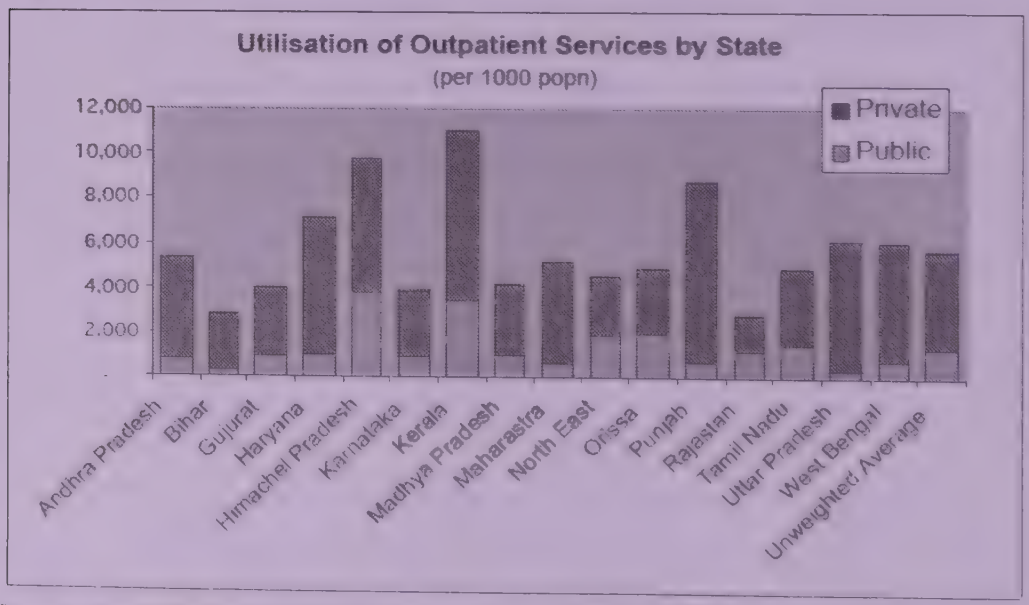
Although it is considered to be one of the largest private healthcare sectors in the world (WHO 2002), there are no conclusive figures regarding the actual size of the private sector in India. However, a recent analysis of various sources of data indicates that in 2002, 62% of hospitals, 54% dispensaries and 35% of beds were in the private sector (Duggal 2007). Compared to the public sector, the private sector dominates with its share of 75% of biomedical doctors and over 90% of non-biomedical doctors. While

facility surveys have been able to garner information on a certain portion of the formal private sector, there is hardly any information on the actual size of the informal sector.

1.2.2. Pattern of use

Data culled out from the 52nd round of the National Sample Survey, National Family Health Survey Round 2 and a National Council of Applied Economic Research study on patterns of utilization of health services with regard to both inpatient and outpatient care indicates that a majority of the population use the private sector for outpatient curative care (Pandav et al. 2005). Based on analysis of the 52nd round of the National Sample Survey, fig.1 presents the state-wise utilization of out-patient services clearly indicating the marked preferences for the private sector.

Fig. 1. Utilisation of Outpatient Services by State

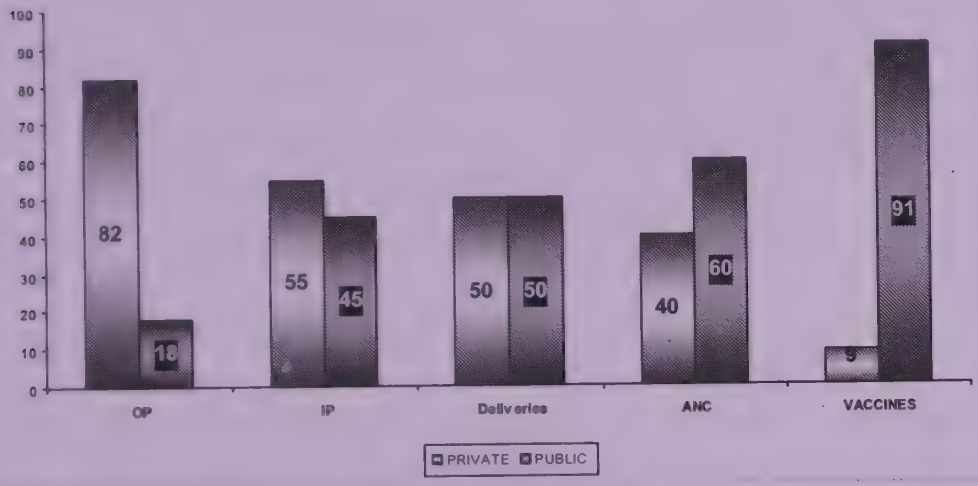


Source Ajay Mahal based on National Sample Survey 1995-96, 52nd Round

Similarly, as illustrated in fig. 2, it is seen that both for outpatient care (where a large majority - 82% - use the private sector whereas

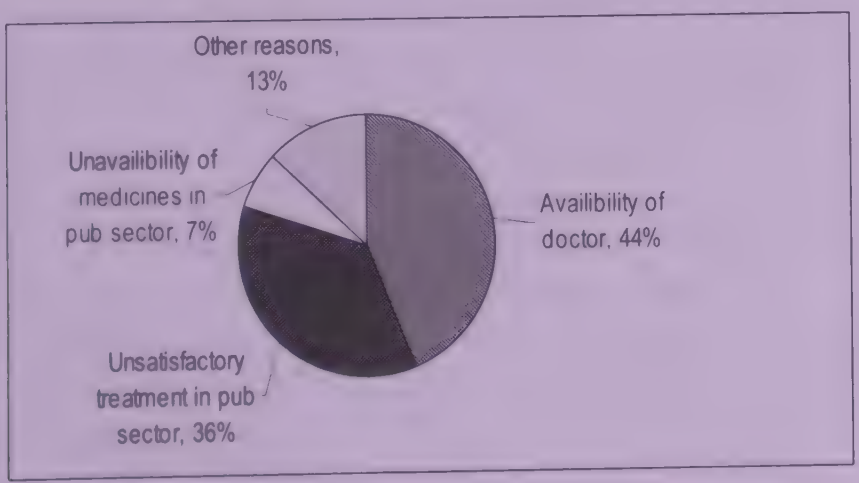
only 18% patients visit the government health centres) as well as for inpatient admissions, the private sector is utilized more (55%) as compared to the government sector (45%).

Fig. 2. Share of Service of Private and Public Health Care



It is widely believed that the private sector responds better to patients' interests than the public sector. The National Sample Survey disaggregates some of the reasons for people choosing the private sector (see fig. 3). Distance is invariably cited as a main problem as government health centres are not located within easy reach of the masses. Also, long waiting times in the public sector is another hindrance to accessibility.

Fig. 3. Reasons for Selecting the Private Sector



1.3. Regulation

Of particular concern in this rapid expansion of the private health sector across the country is that the entities operate in an unregulated environment with no mechanism for standardization of care. Studies from across India have proved that many private practitioners use treatment strategies that are not only unsuitable but often dangerous (Bhalla 2001; Kamat 2001; Bhat 1999; Uplekar et al. 1998; Yesudian 1994).

1.3.1. What exists

The Indian judicial system does not recognize an inherent right to practise medicine. Registration as a medical practitioner in the State Medical Register or the Central Indian Medical Register is a pre-requisite to setting up practice, either in a government-run institute or in the private sector. And the recognition of medical qualifications is subject to national and state laws. There are several legislations in the country which prohibit malpractice in its many forms, be it in unlicensed practice, cross practice or medical negligence. These regulations can be broadly classified as drug related (Pharmacy Act, the Drugs and Cosmetics Act); practice related (Indian Medical Council Act, Human Organ Transplant Act); and facility related (Nursing Homes Act). The private health sector has also been brought under the Consumer Protection Act.

The Medical Council Act, 1956 provides a list of degrees and diplomas which allow practice of allopathic medicine. The Indian Medicine Central Council Act, 1970, pertains to the Indian Systems of Medicine which includes Ayurveda, Siddha and Unani systems of medicine, and the Homeopathic Central Council Act, 1973 concerns regulation of homeopathic practice. Many state governments have also passed laws pertaining to each of these systems of medicine. The Maharashtra Medical Practitioners Act, for example, has an additional list of degrees and diplomas which

entitle practitioners to practise allopathic medicine. In Bihar, the practice of medicine is allowed without any formal qualifications if one is able to satisfy some basic criteria. Similarly, the West Bengal government had allowed certain diploma holders to practise medicine to a limited extent in rural areas.

The public thus has three ways for redressal of grievances:

(a) Complaint to the government health department which refers to the appropriate authorities
(b) Filing a complaint with the police (through a First Information Report), and
(c) Filing a complaint under the Consumer Protection Act.

1.3.2. Does it work?

Despite the existence of laws in the country, however, many of them are out-dated, not adequate enough and those that are adequate are not enforced properly. Lack of awareness among the people, either regarding the existence of these laws or of the measures to seek redressal, is the main reason why many cases of malpractice, especially in the private sector, are not filed (Bhat 1999). Similarly, despite the fact that the Bureau of Indian Standards has developed guidelines for clinical practice in hospitals, and public hospitals often adhere to them, private hospitals generally do not follow these guidelines (Duggal 2007). Although the Drugs and Cosmetics Law has been in existence for the past 53 years, strict enforcement of licensing in drug manufacture, storage and distribution is lacking.

Issues like cross practice and degrees granted by obscure institutions which are not recognized by the states are relatively uncomplicated but issues regarding medical negligence, for instance, are difficult to prove. Notwithstanding the fact that with the enforcement of the Consumer Protection Act in 1986, there has

been an increase in the number of cases filed against medical negligence, as Desai and Chand (2007a) have pointed out, the main challenge in prosecution of a doctor under criminal law is getting fellow doctors to testify against a colleague. A major compounding factor is a Supreme Court ruling that doctors cannot be held criminally liable unless they are proved guilty of 'gross' negligence (Desai 2007). A majority of the successful cases, as these advocates have analyzed, are those which have not required complicated medical evidence. Although a victim of medical negligence has the option of approaching medical councils for redressal, it has been found that most of these councils are overprotective of the registered doctors and are not proactive in ensuring justice (ibid.). Besides, circuitous procedures and time taken to reach judgements in the courts act as major deterrents to seek judicial action. A large number of cases continue to be pending in the courts at the time this report is written.

Many of the laws need to be updated keeping in mind recent developments in the medical world. While issues surrounding 'informed consent' have occupied centre stage in many countries in the West, its definition in the Indian judicial context remains ambiguous. Thus, many cases where such litigations are filed are not successfully resolved for want of a clearer definition of its connotations. For instance, there is no law that prevents a doctor who has only an MBBS degree from practising as a specialist in cardiology or ENT, etc. (Desai and Chand 2007b). Since a practitioner is liable to be held guilty only if a case of negligence has been filed against him, in many instances where a doctor commits an error in prescribing treatment where specialized knowledge is required, is not held for malpractice as there is no legislation prohibiting it in the first place.

The rapid expansion of the *informal* private sector is an area of particular concern. This sector is dominated by practitioners who are either untrained in any system of medicine or trained in

one system and practise another or those who are less than qualified. While it has been well over 15 years since the Supreme Court banned quackery, it is estimated that untrained, unlicensed practitioners outnumber qualified medical doctors by at least 10:1 (World Bank 2004). The increasing number of media reports and court cases in the country are testimony to the rampant malpractices in this sector. The Indian Medical Association had suggested that these quacks be registered and brought under the responsibility of Primary Health Centres and qualified doctors in rural areas to try and gain a semblance of accountability, but a majority of these practitioners continue to practise outside the ambit of formal surveys.

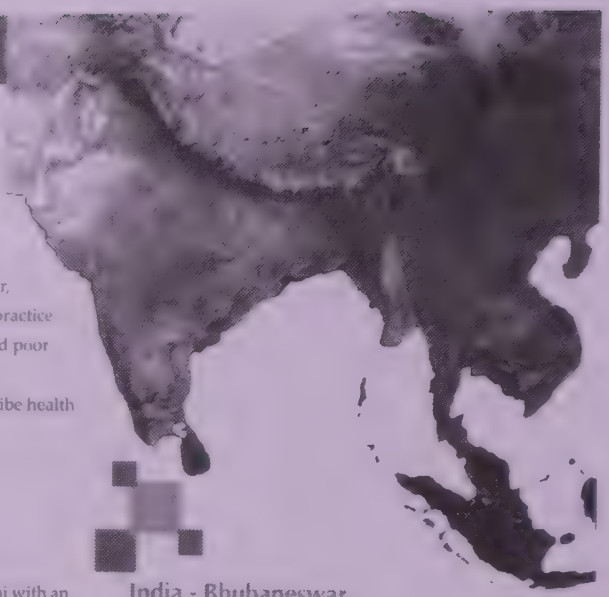
The absence of a nation-wide focus on the private health sector is responsible for the lack of a clear and integrated legislative framework. Inter-state variation regarding recognition of diplomas and short-term qualifications hampers a clear understanding of the issue surrounding Registered Medical Practitioners and the legal actions they are liable to in states other than where they obtained certification. While the NGO sector operates in a relatively more regulated manner, it comprises a small fraction of health care services in the country – less than 1% in most states (World Bank 2004) – and there is no comprehensive analysis of regulation in health service provision by NGOs.

It is, therefore, a grim picture. With the exponential growth of the population, there is pressure on an already unresponsive public sector. And the undeterred growth of the private sector without appropriate regulations means that the poor and the vulnerable are rendered even more vulnerable.

The Project

The HSRE project started in the year 2004 and is scheduled to end in 2007. Objectives of the project are summarised below:

- To identify feasible regulatory mechanisms and strategies for the private healthcare sector,
- To identify systematic constraints in private practice
- To determine constraints for practitioners' and poor patients' treatment-related decision-making
- To compare findings across centres and describe health policy implications.



India - New Delhi

Midan Puri is a slum cluster located in South Delhi with an estimated total population of 12-15,000. Composed largely of migrants from neighbouring states, most inhabitants are daily wage earners. All houses have unauthorised electricity connections and there is no regular water supply. 'Midan Puri' has received an eviction notice from the Municipal Corporation of Delhi. There is no government health centre in the area. Health care facilities are provided by two free dispensaries run by NGOs. The study shows that the first point of contact with the health system for 93% of the inhabitants is the private practitioner inside the slum. There are 22 such clinics run by practitioners without formal medical qualifications.

India - Bhubaneswar

Bhubaneswar, Orissa, has a high growth rate, and immigrants who typically belong to scheduled tribes and scheduled castes largely live in slum settlements (bastis). 'Beluam' basti has 550 households and approx. 2500 inhabitants. Average household size was 4.4, resulting in a monthly mean per capita income of INR 720. With 31% (40% women and 23% men) having no formal education, and 24% having only primary school education, this community is very vulnerable to unforeseen expenses caused by ill health. The health system in Bhubaneswar is characterised by a pluralism of biomedical, homeopathic and ayurvedic practitioners and traditional healers. But, in contrast to Delhi, there is a relative absence of practitioners who do not possess the required qualifications within the tradition they seemingly represent. At the same time, the study found that drug stores frequently diagnose disease and prescribe medicines that should be prescribed by a medical doctor.

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Continude on page no. 52

2

The Project

2.1 Delhi: The urban complex

Delhi, the national capital, is one of the richest regions in the country. With a population of over 13 million (MoHFW/UHRC 2007), the city not only has the highest population density of 9224/ sq.km (Planning Commission 2008) but also the highest percentage of urban population among all states and Union Territories in the country. Nearly half of Delhi, however, lives in poor habitations. More than 15% of the population do not have access to piped water and one-fourth do not have access to toilet facilities. Largely involved in the informal sector, they face constant threat of eviction and almost non-existent social security cover.

While the largest majority of this population lives in slums, urban/ urbanized villages, resettlement colonies, Harijan bastis and *Jhuggi-Jhopdi* clusters, there are huge groups who live in squatter settlements, construction sites, unauthorized colonies, and on pavements. Much of the latter comprise 'missing populations' which are not recorded in any population survey and thus excluded from any public health interventions. Thus, there is no conclusive data on the exact number of urban poor in the city. The Planning Commission (2008) estimates that 64.5% of the total population live in *jhuggi-jhopdi* clusters, slums and unauthorized colonies while another source estimates that 20% of the total population (approximately 3 million) live in slums. Yet another estimate puts the number at 18.7 lakhs. An NGO, Asray Adhikar Abhiyan, estimates that there are 100,000 homeless in Delhi. Large scale migration into the city each year makes estimates even more difficult.

Despite the ambiguity in numbers, however, there is no denying the abysmal critical health indicators among this population. Neo-natal mortality rate (39.3), infant mortality rate (94.4) and child mortality rate (135.5) among the urban poor (MoHFW/UHRC 2007) in the city are among the highest in the country. There are several outbreaks of vaccine preventable diseases. Only 25% are fully immunized by age one year. There is high anaemia prevalence and nearly half of the urban poor children are malnourished and face an increased burden of diseases such as measles, diarrhoea, diphtheria, whooping cough and tetanus. Ante-natal coverage is low as about one-third of the pregnant women receive three or more antenatal check-ups. Use of spacing methods is low and total fertility rate is high at 4.8. Malaria prevalence is more than double that of urban high-income groups and TB prevalence (1315/1000) is more than double that of the urban average.

There are 34 hospitals in the city (11 government-run and 23 private), 166 dispensaries and health centres. Irrespective of the large number of medical facilities and free government-run institutions, health service in Delhi is provided by the private sector in most urban poor areas. While there are a total of 38,852 registered

medical practitioners in the city[1], there are a very large, although un-mapped, number of informal providers of medical care. The Indian Medical Association estimates that there are 40,000 unregistered medical practitioners in the city who are not trained in any system of medicine[2], and that there are two 'quacks' for every registered medical practitioner. Providing largely curative services, these practitioners make regular headlines in the media in the aftermath of fatal accidents caused by misdiagnoses, and the Delhi government conducts raids in an attempt to shut their 'clinics'. Although the Supreme Court of India has deemed their operations to be illegal (Peters et. al 2002), the fact remains that most of these 'quacks' continue to practice, albeit in many cases in clinics that bear no signboards or placards.

The Project undertook this study in a poor settlement in Delhi to explore the context in which these practitioners operate, the nature of their practice, and the reasons why respondents from the neighbourhood under study prefer to consult them, in the face of other available options, when they are confronted with illness.

2.2 Selection of the field site

The research site in Delhi was finalized in two stages. An initial list of slums in Delhi was procured from the Municipal Corporation of Delhi. Eight areas were initially short-listed and visits were made to Subhash Camp (Ambedkar Nagar), Sanjay Basti (Timarpur), Nizamuddin Basti (near Khusra Park), Indira 1st and 2nd Camp (Srinivaspuri), Harijan Colony (Tilak Nagar), Sanjay Colony (Badarpur), Midanpuri (Vasant Vihar) and Madanpur Khadar (Sarita Vihar). A tentative selection of Indira Camp in Andrews Ganj in south Delhi was done thereafter in April 2004. Initial research was carried out in Indira Camp to map the area. However, due to a perceived threat of demolition of the slum and eviction of its inhabitants by the Municipal Corporation of Delhi, an alternative site was chosen for the study.

Midanpuri in south Delhi was subsequently finalized in June 2004 as the research site for the project. The selection of the neighbourhood was done on the basis of several key criteria: its large population size, presence of sizeable number of private practitioners practising in the neighbourhood, plurality of medical practices, and accessibility of the area from the project office at AIIMS.

The name of the slum has been changed in order to maintain anonymity of the field site.

2.3 Training of research personnel

Research personnel recruited in the project team at AIIMS were trained in qualitative research and methodology. Specific modules were prepared on:

- Presentation of the project to participants in the field
- The basics of narrative approach to interviewing
- The concept of bias and the relationship between observation and interviewing
- Conducting unstructured and semi-structured interviews with private practitioners and patients/families
- Conducting participant observation in the field

- Creating and maintaining field notes according to the prescribed format
- Translation and transcription of interviews and field notes according to the prescribed format
- Research ethics (in particular, verbal informed consent, confidentiality and protection of data and how to deal with ethical dilemmas in the project)

The training schedule comprised a series of didactic sessions accompanied by many practical exercises and mapping of selected field sites using participatory techniques. Most of the practical sessions revolved around role playing and conducting interviews, note taking and making transcriptions of the interviews. A comprehensive training report was prepared at the end of the training period. The training report is appended to the monograph (see Annex 5). Follow-up training continued as data collection progressed.

Further, after data collection began, training was provided in the use of the software application q.s.r. Nvivo for the qualitative data analysis process.

2.4 Methodology

Mapping

Initial mapping of the field area was done using participatory techniques. Given the size of the population, it was not possible to geographically plot all the households in a map. Several transect walks through the neighbourhood and group discussions with the residents of the settlement were used to chart an approximate map of the area with its five 'blocks' (A, B,C, D and E), all major lanes and important landmarks. The locations of all private practitioners of different categories, who practise in the area, including one chemist, were marked.

A detailed digital map (to scale) of the neighbourhood was also prepared. Due to the very large area, it was decided that an approximate household mapping would be done of the entire area and three 'blocks' (clusters) covering approximately 500 households would be selected for detailed household mapping. All the households were selected from these blocks, namely A, C, and E. All the private clinics within the neighbourhood were plotted. In addition, private medical facilities utilized by the respondents within an area of approximately 4-5 km radius from the neighbourhood were also marked.

Selection of respondents

Fieldwork for the study was conducted over a two-year period from June 2004 to May 2006. Data collection commenced after the recce and mapping exercise. Two ethnographic sub-studies were carried out simultaneously: sub-study 2 on private practitioners and sub-study 3 on family-level treatment decision making. All private practitioners with clinics in the neighbourhood were identified and personally visited.

Sub-study 2: A total of 25 private practitioners were enrolled for the study. Of the 15 private practitioners located within the slum when fieldwork began, 10 agreed to be part of the research in the first three months. Three other practitioners outside the neighbourhood (2 in Malviya Nagar and 1 in neighbouring Mahipalpur) were identified on the basis of patient references. All of them, however, declined to participate in the study. The number of clinics in the settlement increased as data collection ensued. By June 2005, a total of 18 private practitioners located in the slum, and by the end of the year 7 private practitioners located in markets within a 3-4 kilometre radius from the settlement, were recruited. The latter group are all licensed biomedical doctors identified on the basis of household utilization indications.

Sub-study 3: From a total of 207 households that were enrolled to track household expenditure on health through the use of a

questionnaire (sub-study 4), 25 households were selected for in-depth case studies to explore the families' treatment seeking behavior and, in particular, to examine decision-making processes and reasons for choice between private and public health services. Although the process of identification of key respondents had begun in June 2004, household level interviews for case studies began 4 months later. Respondents were selected randomly by selecting one household at a time, obtaining consent and then selecting the next household. Although all 208 household members were listed, key respondents were selected for interviews. Where possible, respondents were also selected during exit interviews at the clinics of practitioners.

Approach

A combination of ethnographic methods was deployed to generate data for both sub-studies. Unstructured, and later semi-structured, interviews were combined with observation in both households as well as clinics. Although a primary respondent was selected from each household, other members of the household were frequent sources of information and were encouraged to participate in the interview sessions and to share their experiences.

Group discussions were held to elicit individual and collective responses on possible measures to improve health care in slums. Interviews were all conducted in the homes of the respondents. All the households were visited at least once a month. Extensive field notes were taken to record the observations. The duration of the interviews were of an average of 45-60 minutes although in many cases these interviews continued up to 2 hours. Almost all the interviews were audio-taped and conducted in Hindi, the local language, translated into English and subsequently transcribed. The interviews were initially manually examined and transcriptions were subsequently imported into the qualitative data analysis software package q.s.r. Nvivo for coding and content analysis. Pseudonyms were used to protect the patients' and practitioners' confidentiality. Data analysis was carried out simultaneously as fieldwork progressed and guided data collection.

During analysis the recorded interviews were regularly revisited to ensure accuracy of transcriptions and to make sure that important data were not lost in the process. Coding themes and concepts were empirically driven and developed from experiential accounts of respondents using the Grounded Theory approach (Strauss and Corbin 1990). Scheurich (cf. Werner, Isaksen and Malterud 2004) writes that "reality is not something out in the universe to be discovered, but rather is contingent upon people who construct it". Thus, patient narratives serve as a medium to explain, present and negotiate the meaning of illness (Hyden 1997) and provide an avenue to link an "inner emotional world" with "an external phenomenal world of actions and circumstances" (Mattingly and Garro 1994). These narratives were used both to construct the experiential reality as well as to explore the various institutional structures that influence the production of the life stories. Analysis of these narratives made it possible to not only situate the physician and patient in their socio-cultural milieu but also provided insight into the meanings given by both the actors to a common event, viz. illness.

2.5 Challenges

A number of problems were encountered during the course of the study. Data collection was carried out amidst considerable difficulties posed by the specific field situation. Access to the unregistered private practitioners located inside the settlement was very difficult. A majority of the private practitioners that we contacted during the first 3 months of fieldwork refused to cooperate in the study and the few that did, pulled out after initially agreeing to do so. Identification cards of the field research team were retained by one of the private practitioners who allegedly occupies a position as a senior office bearer of an association of informal health care providers in south Delhi.

Another problem concerned sharing of information by the private practitioners. They were unwilling to provide certain types of information. There was particular reluctance to allow the researcher to observe interactions between the private practitioner and his patients. They were also unwilling to provide information on specific drugs used for treatment. Recognizing that this was difficult research terrain, access strategies were modified as data collection progressed. It was agreed that if the practitioner would not be willing to share certain types of information, the researcher would not persist with those questions. This has resulted in a range of different information on the participating clinics. It was only at the end of 8 months did the project team enlist 25 practitioners. These access problems could be attributed to their liminal status, especially against the backdrop of raids that were being conducted in slums across the city to close the clinics run by under-qualified private practitioners and reporting by the electronic and print media of cases of malpractice by these practitioners. Even as the research team progressively managed to override these problems, difficulties in retaining the private practitioners persisted throughout the duration of fieldwork. At the end of the study, although certain details of their practice are still not known, a greater understanding of the sector as a whole has been achieved.

During the course of fieldwork, ethical dilemmas arose when the field researchers directly observed practices by private practitioners that were harmful to the patients (for instance, see box). After discussions with the larger project team, it was decided that if it had to do with life threatening disease that can be helped by urgent intervention of the researcher, this would take precedence over the research project. In other cases, it was decided that the team would offer advice to the patients about appropriate treatment consulting options when solicited and in cases where the treatment offered was seen as particularly dangerous.

Antibiotic for infant diarrhoea?

Six patients (five women and one man) sit in the practitioner's room waiting for their turn to consult him. Out of the five women, four carry infants, all suffering from diarrhea. As soon as each infant is presented to the practitioner, he first takes a thermometer dipped in a small stainless steel bowl of water kept on his table and puts it into the mouth of the infant, takes it out after one minute, and places it back in the bowl. The water in the bowl, the observer notes, has turned dark grayish and looks murky. The practitioner gives the same medicine to all the cases: he cuts six tablets from a strip and hands them to the mother with the instruction that the tablets be ground and mixed with water and fed to the infant twice a day for three days. Each consultation lasts approximately 3-5 minutes.

Subsequent analysis of the medicine reveals that it is an antibiotic (a strong combination of Tinidazole and Norfloxacin) which is not recommended for children and never prescribed for infants. During a subsequent interview with the practitioner, when the researcher questions him about the soiled water in the bowl, he is nonplussed, and says that there can be no question of infection as "there is no such concept among children". He does not possess any degree in any system of medicine but says that his knowledge of "bimari aur illaj" (ill health and treatment) is "inherited".

At the household level, no significant problems were encountered in enlisting respondents. However, the lives of the respondents are demanding and they do not have enough time to sit for long interviews. There was considerable survey fatigue and there were persistent enquiries about compensation for time spent in cooperating in a study that would span close to two years. Further, the research team was constantly asked for help – for admission into schools for their children, financial help for surgeries, for jobs and for admission into hospitals.

There was particular reluctance to share information on household income and expenditure and much of the initial information was found to be misleading as data collection progressed. This could possibly be attributed to the wide-scale demolition of slums throughout the city as part of the Master Plan for Delhi 2021which seeks to make Delhi free from slums. Constant fear of sudden eviction from the settlement among the inhabitants made them insecure and nervous about sharing financial details. The suitability of using a questionnaire to collect health-related data in sub-study 4 is critically examined as the project team encountered significant problems both while conducting fieldwork as well as during the analysis stage. When the questionnaire used for sub-study 4 was employed by one of the authors of this report on households where case studies were documented towards the end of fieldwork, major differences were noted between responses during the survey rounds and during the more detailed interviews in the household study. It is clear, therefore, that analysis of survey responses alone cannot capture the nuances of family dynamics and relationships which are important determinants of care seeking.

2.6 Providing assurance to the field

Privacy, confidentiality and informed consent were assured to all the respondents. It was decided to involve participants based on oral informed consent, rather than written informed consent. After several months spent in the field and much deliberation within the

project team, it was decided that a token compensation would be paid to all respondents of sub-studies 2, 3 and 4 for the time spent with the research team. A symbolic compensation was paid to the private practitioners to offset any loss of patients during the time when they partcipated in the interviews by the researchers. A focus group discussion with members of the households participating in sub-study 3 resulted in the decision to give pressure cookers to those households. These pressure cookers were disbursed at the end of the fieldwork. Compensation was very well received by all respondents and has been a vital incentive in retaining participation of the private practitioners during the study.

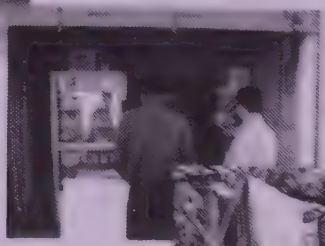
Further, a **health camp** was organized by the Centre for Community Medicine in February 2008. A staff of 16, including six doctors, attended to 300 patients. Medicines were given for basic ailments and the more complicated cases were referred to specific departments at AIIMS. Posters on health education were displayed and the Centre's health education specialist gave engaging talks on

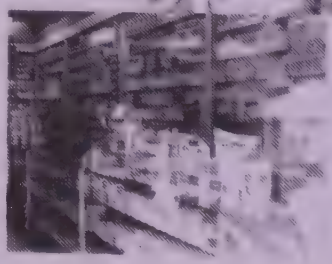
different public health issues to students from the slum (who attend the Municipal Corporation school) and to the residents who came for the camp. All the case study households attended the health camp.

Indonesia - Jogjakarta

Jogjakarta is 30 square miles wide with many health resources. Outlets include small kiosks, providers of alternative medicines, private clinics and hospitals and government hospitals. The population in the study site is characterized by low income, poor sanitation, high population density. Most of the families reside at the river bank and near the railway track. Their houses are made of bamboo, semi-concrete or concrete. Access to clean water, toilet, and other public facilities is very limited

The study involved 34 households and 29 private practitioners for the qualitative part and 220 households for the quantitative part. Practitioners participating in the study included nine doctors, three midwives, four nurses, six traditional healers, two polyclinics, three medicine stalls, one medicine store, and one pharmacy. Other than private practitioners, each sub-district has its own primary health centre clinic and sub-health centre with activities every two or three months, such as mobile clinics for children and for general problems, for geriatric problems and for reproductive health





Thailand - Phitsanulok

Phitsanulok municipality has approx. 100,000 inhabitants and is located in northern Thailand. A centre for migration from rural areas of the lower northern region of Thailand, it is estimated that around 10% of the population in Phitsanulok live below the poverty line

Two neighbourhoods were included in the study. Most of the inhabitants are migrants and earn daily wages. Both areas have electricity and water supply. One neighbourhood has a high migration rate and many live in temporary, rented dwellings. People in the other neighbourhood own their houses but not the land. Both areas have a primary care unit (PCU) that provides health services under the universal insurance scheme. Migrants who are not registered as local citizens do not have access to public health services under the universal insurance scheme and thus visit private health practitioners and drug stores which are easily accessible for people in both neighbourhoods.

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3

Seeking Health Care in Midanpuri

3.1 Multiple vulnerabilities

Midanpuri is a slum settlement located in south Delhi near one of the city's most affluent neighbourhoods. With an estimated population size of around 25-30,000, it is composed almost entirely of migrants from neighbouring villages and from the states of Uttar Pradesh, Rajasthan, Bihar, Haryana, Madhya Pradesh, Uttaranchal, Kerala, Karnataka and Andhra Pradesh.

The settlement finds mention in the Municipal Corporation of Delhi's list of *jhuggi-jhopdi* colonies. According to the Delhi Master Plan of 1962 (a statutory document drawn up in accordance with the Delhi Development Act to provide planned development in the city), Midanpuri was established in the 1970s on *Gaon Sabha* land of Mahipalpur. This implies that it is common land of the village governed by the Delhi Land Reforms Act 1954 belonging to the *Gram Sabha* - a body consisting of persons registered in the electoral rolls relating to a village comprised within – meant for common use by the villagers. The custodian of the *Gaon Sabha* land is the Block Development Officer of the district. The Municipal Corporation informed us that the settlement is 'covered' by the mobile health scheme of the Government of Delhi. However, respondents from the field said that although a mobile health clinic used to visit the settlement once in 2 weeks until about 2 years ago, no government sponsored health initiatives in the area have taken place in the area since.

A typical area of "concentrated disadvantage" (Vlahov et al. 2007), the settlement has densely packed shelters; many built with

concrete and tin roofs but a majority with flammable roofs. Single room hutments of approximately 50 sq.m. each, they have high occupancy rates of an average of six persons per household. They serve as an all-purpose room generally demarcated into a sleeping area and a cooking area. All the houses are served by illegal electricity connections provided by a local 'contractor' for a monthly fee.

There is no regular water supply in the settlement. The inhabitants are dependent on two communal water sources which provide water for 2 hours in a day and on water tankers that come once a day, and often in the summer once in two days, from the Delhi Water Supply department. During the course of fieldwork, the research team has been witness to stampedes in the area to collect water when these tankers arrive. A 5 year old child was killed in such a stampede in May 2005.There are no toilet facilities inside the slum and the people use the open fields and surrounding scrub areas behind the slum to defecate. There is a *Sulabh Sauchalaya* (a public toilet system developed by the Sulabh

International Social Service Organisation) in the heart of the slum but it has been non-functional since 1998 because of the lack of water in the area. There is virtually no drainage in the settlement and during heavy rains the main entrance gets blocked. The undulating layout of the slum, however, enables the main bye-lanes to remain clear during rains.

Almost 80% are wage labourers; they work as cleaners, auto-rickshaw drivers, guards in private offices, vegetable vendors and carpenters with a striking majority of the women working as domestic help in the neighbouring areas of Vasant Vihar, Vasant Kunj and Munirka.

There are 27 clinics run by private individual health care providers in the slum. We borrow Berman's (1998) term 'less-than-fully-qualified' to refer to these practitioners who are partially qualified or possess little or no formal training in allopathy. An antenatal care clinic run by an NGO called Asha located in the slum. In addition, two free dispensaries are located in the outer

periphery. Run by charitable organizations, these dispensaries are used largely for eye problems and child health conditions. One dispensary is run by a Gurudwara (Sikh temple) and the other by the Arya Samaj (a "Hindu" reformist organisation that began in the late nineteenth century). There is no government health centre in the slum with the two closest dispensaries being located approximately 3 kilometres away, one in Ber Sarai and the other in Mahipalpur. There is one pharmacy located inside the settlement. Owned by a private individual and manned by a hired help, it sells medicines on the basis of their marked up price. The helper refused to participate in the study as the owner of his shop declined permission to do so. The only information forthcoming from him was that the drug sales are low as compared to the rental that they have to cover.

Having received an eviction notice from the Government of Delhi in January 2004, the residents of Midanpuri were in a state of turmoil as the project team conducted fieldwork. In a context of chronic crisis, marked by crippling scarcity, poverty, ill health and spiralling debt, the threat of sudden displacement added a major dimension to an already desperate situation.

3.2 Treatment seeking behaviour

3.2.1 Vulnerability to disease

The lack of basic infrastructure impacts all aspects of the inhabitants' life in Midanpuri. As in other areas of urban poverty, the high population density, waste collection pits, open sewers, absence of toilets, and the lack of regular water supply contribute to the high reporting of illness. At least 1 member from a household reported visits to a medical practitioner once every 5 days. While there is no slum specific data on morbidity, every household we interviewed reported at least 2 illnesses most of which could be classified as acute respiratory problems and water borne diseases.

During the summer months there was a surge in epidemic prone infections. In all, 31 chronic conditions were reported from the 25 households (on the basis of a classification of a chronic condition as one lasting three months or more). Although there was general awareness about sexually transmitted diseases and HIV/AIDS, largely gleaned from media campaigns, knowledge regarding its methods of transmission was very poor.

High alcohol consumption poses a major problem in the slum. Repeated brawls often culminate in physical fights and injuries. This posed a safety threat to the researchers in the field. After encountering several problems during fieldwork, it was decided that the field researchers would leave the area well before dark. Among males, drug use is common. While assessment of patterns of substance use is not part of the study, it was found that *gutka* (crushed betel nut, tobacco, catechu, lime and flavourings) and powdered tobacco are very commonly used. A large number of men are also dependent on sedatives of various kinds (benzodiazepines, barbiturates and other tranquilizers).

A large number of mental conditions were recorded. Apart from the 11 cases of mental illnesses which were reported from the households, there were a large number of cases that were noted by the researchers during fieldwork. Most of these cases remain undiagnosed and labels range from "disturbed", "unstable" to "mad". In the households, with the exception of 3 cases which have been certified by doctors in government hospitals, the remaining were classified by the respondents as "man ki bimari" (mental illness). The latter had sought traditional healers for treatment. As Subba et al (2004) found in their study of slums in central Delhi, lack of awareness regarding mental disorders were found to prevent them from seeking medical treatment.

3.2.2 Gender correlates

Previous work in this area has documented that high levels of ill-health in India are for the most part endured by the women. The situation in Midanpuri is no different. Utilization of health care services for reproductive tract infections and sexually transmitted infections was found to be low. Almost two-thirds of the women reported that they suffer from gynaecological conditions with a vast majority citing vaginal discharge leading to fatigue as the most disruptive condition. Domestic violence is rampant. Although the women were reluctant to talk about this issue, almost half of them appeared to be victims of domestic violence. Interpreted purely as physical violence with no reference to psychological violence, a majority of cases were attributed by the women to high alcohol use by the husbands.

The male-female disparity in health related decision making in India is well known (Das Gupta 1987; Santow 1995). Usually, decision making for the women is a household rather than an individual matter and is influenced strongly by the dynamics within her family. However, better access to cash resources in the present setting relative to their rural counterparts, or their previous lives in

rural settings, seems to have had a positive influence on the decision to seek care and health care utilization - both for their child as well as for themselves. Women who have lived in Delhi for the past 10 years and more reported a higher freedom of movement and more active decision making to seek treatment than in rural areas although the women's access to resources continued to be influenced by the head of the household. In case of households where the father-in-law or the brother-in-law was the head of the household, her access to resources and decision making for seeking health care was found to be far more constrained than in cases where her husband was the head of the household.

Despite the availability of institutional delivery services in the city, 51 of 134 (38%) deliveries were reported to have taken place in hospitals relative to the majority that delivered at home with the help of traditional birth attendants. The custom of primiparous women to return home to their village for their delivery adds to the number of home births that have been reported. Of the 51 deliveries, 42 had taken place in government hospitals and the remaining in private facilities.

3.2.3 I prefer only private...

What the respondents looked for was basic care. There was a single-minded focus on getting immediate 'action' with a purpose to return to work as quickly as possible. Assessment of 'best' treatment was done on the basis of cost and perceived quality of treatment. All the people that were interviewed, almost without exception, said that they visit private health facilities when they fall ill, either in the neighbourhood or outside. Private practitioners within the *jhuggi* were cited as the first point of resort in case of "everyday illness conditions" like cold, cough, fevers, headache, joint pains, and minor injuries. For conditions which required "further treatment", private practitioners in the neighbouring areas were consulted. Instances of such conditions are TB, heart disease, acute

respiratory conditions, HIV/AIDS, and other chronic conditions. While the neihgbourhood practitioners were the first point of resort for primary care, the dispensary run by the NGO, Asha, was universally preferred for antenatal care. The main reason for this was the outreach programme run by the NGO where community workers have been employed to disseminate information on antenatal care and to guide women to the centre. During the two years of fieldwork, only 2 cases were reported of visits to the government dispensary in Ber Sarai. The need to commute to the dispensary, the long waiting time and the lack of medicines in the dispensary were cited as deterrents to visit the dispensary.

The widespread ambivalence towards government institutions was linked to the time-consuming, circuitous procedures and the indifferent care associated with government facilities. Further, several respondents recounted how they had to pay bribes to staff in government hospitals to get ahead in the waiting line. In contrast, positive responses to satisfaction of service received from the private health care providers were tied to clinic opening times, fees, waiting times, and accessibility of the practitioners.

However, government hospitals were invariably cited as the main option in connection with conditions which are either considered to be "serious" or those that require inpatient care and surgical intervention. The city's most well known public hospitals, Safdarjung Hospital and AIIMS, were the main choice. A total of 69 episodes of hospitalization were recorded within a recall period of one year in the last year of fieldwork in the 25 households.

Unlike studies in slums elsewhere (Awasthi et al. 2008; D'Souza 2003; Papreen et al. 2000), there was little mention of traditional healers; the only exceptions being for male sexual health and mental illness. Biomedical treatment or allopathy was the first point of resort in all other cases. Interestingly, there were very few instances of home remedies.

3.2.4 Determinants of choice

The decision to seek medical care was seldom guided by the perceived cause of illness. Rather, it was a pragmatic decision to deal with the condition effectively enough to return to work as quickly as possible with the available resources at that time. The role of 'cultural factors', therefore, was found to be minimal.

- *Access*: Access was found to be the major determinant of health seeking behaviour. Physical access (distance to the clinic, availability of the practitioner and ready dispensation of drugs) was cited as the most important factor. This was followed closely by social access
- *Cost:* The low fees and the flexible payment options were extremely convenient for wage earners
- *Quality of care:* The private practitioners were reported to "give more attention" in comparison to the government facilities which were considered too slow and "difficult to deal with". Besides, the ready dispensation of medicines and administration of injections (often on demand) qualified as "better care".
- *Prior experience:* Selection of the specific practitioner(s) was informed by networks within the neighbourhood, either members of the family, kin group or neighbours that inform health care seeking. Prior experience of consultations with the practitioner also mediated choice to a large extent.

Predominant in patient narratives, across gender, was dissatisfaction with treatment received for much of their health conditions. In a majority of cases, this could perhaps be linked to the irregularity of treatment. In two-thirds of the 92 illness trajectories that were documented in detail, practitioners were changed more than 4 times. Amongst the reasons given for switching providers, from both the public and private sectors were convenience, better quality of treatment and price. The furthest that a patient had travelled to was 1 hour away by bus for a particular private practitioner who had cured a neighbour's son of kidney stones.

3.2.5 Drug use

It was found that the chemist in Midanpuri was used to purchase medicines either when a prescription had been written out by a qualified medical practitioner, either public or private, or when specific medicines were sought directly by the patient. Rampant over-the-counter sale of prescription drugs, in particular Alprax (alprazolam) was recorded. Recently, the Central Government put all psychotropic medication under the Narcotics and Psychotropic Substances Act of 1985. Under this Act, chemists and druggists are supposed to keep a record of sales of psychotropic medicines for a period of two years. But the chemist in Midanpuri was found to routinely sell Alprax without a prescription.

Since the chemist declined to participate in the study, preferences by members of the households were recorded. The three most common medicines were Brufen 600 mg (ibuprofen), Ibru Plus (ibuprofen, paracetamol and magnesium oxide), Alprax 1 mg and D-Cold Total (Paracetamol I.P 500 mg + Caffeine Anhydrous I.P 32 mg+ Phenylephrine HCL I.P 10 mg + CExcipients).

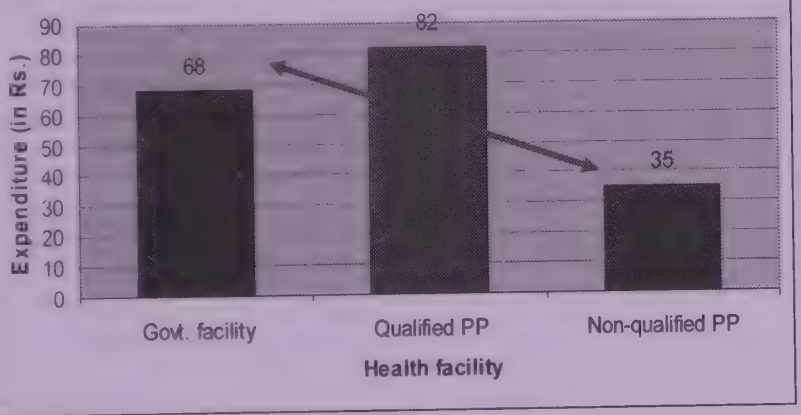
3.3 Expenditure on health

The high incidence of morbidity imposed a costly toll on most households; not only did the medical costs deplete their already precarious financial condition, but the inability to earn during the period were found to inflict a double burden which often pushed them into debt traps.

Nichter (1996) observed that they poor want "the best medicine at the lowest price". At first instance, while this sentence might appear to be an apt description, it is important to unpack what is considered 'best' in *specific* situations. In this particular context, the main imperative was to return to work as quickly as possible driven by the insecurities of income and tenure. The cost of consulting a neighbourhood less-than-fully-qualified practitioner,

considered to be accessible to almost everyone in the settlement at Rs 35 per visit, compared favourably to not only qualified private practitioners but even government-run facilities. While consultation with a doctor in a government facility is free, transportation and more importantly, purchase of medicines from a pharmacy was found to drive costs to an average of Rs 68 per visit, which was almost twice that of a less-than-fully-qualified practitioner. Often, additional costs were inflicted when circuitous procedures and long queues in the hospitals resulted in losing the day's wages.

Fig. 4: Avg. Expenditure on Healthcare



A visit to a qualified private practitioner who charges on a fee-for-service basis was the most expensive (see fig. 4) with the average cost of Rs 82 per visit but location access and quicker service made it a convenient option. Free samples received by these practitioners from medical representatives were often found to be given to the patient which was an additional incentive.

Notwithstanding cost of health care being one of the main determinants in choosing a treatment provider, a large number of people in fact said that they would be willing to pay for higher quality care which, as they lamented time and again, was neither accessible nor available to them.

SUB-STUDIES

Sub-study 1: Ethics and Law

This study reviews existing regulatory mechanisms, ethical codes and legislation with direct implications for general/private practice in addition to existing literature on the subject in India, Indonesia and Thailand. In addition, recent court cases or cases brought before relevant regulatory or disciplinary bodies concerning (un)ethical practice of private practitioners, if any, will be reviewed, based on existing literature (including news media and other sources)

Sub-study 2: Private Practitioners

This sub-study is a descriptive study of health systems at micro level to explore health-related decision-making processes, contextual factors and underlying ethical values in the clinics of private healthcare practitioners (irrespective of type of medicine practised). The study is based on the assumption supported by existing scientific literature that certain types of ethical problems and dilemmas (including issues related to diagnostics, prescription practices and information management) can have severe negative implications for individual and public health.

Research questions include:

Repeated participant observation was adopted during field work in clinics during doctor-patient interactions. Unstructured interview techniques were combined with the use of a semi-structured approach at later stages of the project. The confidentiality of all participants was protected at all stages of the project.

Sub-study 3: Poor Households - qualitative

This sub-study explores user perceptions on use of private practitioners' services. It is considered essential to include this component in order to assess the implications for the patients of the health delivery system explored in sub-study 2

It will describe the resource allocation of approximately 25 families to systematically see how decisions are made in the families and for whose benefit. Furthermore, this component will explore how the resources are utilized vis-à-vis the locally available health system. Here, any kind of treatment that the family undertakes as a relevant step to counter the suffering related to a perceived health problem as well as the related constructions of gender, age and personhood (autonomy) have been recorded.

Sub-study 4: Poor Households - health economics survey

This sub-study is a health economy assessment of resources spent on health and economical consequences of ill-health in poor neighbourhoods. Central research questions include: Establishment of baseline, assessment of basic facilities, assessment of home production, assessment of coping mechanism for families, assessment of economic health consequences through sequential follow-up of depletion, and assessment of non-economic health consequences for families The survey was carried out four times over a period of 12 months.

Partners

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- Centre for Community Medicine, All India Institute of Medical Sciences (AIIMS), New Delhi, India
- Center for Bioethics and Medical Humanities (CBMH), Jogjakarta, Indonesia
- Centre for Health Equity Monitoring (CHEM), Naresuan University, Phitsanulok, Thailand

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4

Private Practitioners of Midanpuri

4.1 Being a 'doctor'...

During the 2 years of field work, the number of clinics run by less-than-fully-qualified private practitioners in Midanpuri increased from 15 to 27. During the initial months of data collection, most of the 18 less-than-fully-qualified practitioners enrolled in the study insisted that they were all 'registered practitioners' of the Indian Systems of Medicine but at the end of the fieldwork, we found that only 5 of them had documents certifying that they were Registered Medical Practitioners; the rest were unlicensed practitioners, not registered in any system of medicine. Three-fourths were undergraduate and did not possess formal degrees and the remaining were 'trained' outside Delhi through short-term diploma courses in Ayurveda and Homeopathy. Seven of them produced certificates from institutions which are not recognized by the government.

All of them, without exception, were foumd tomadminister biomedical drugs. During the entire span of fieldwork, very few instances were recorded where non-biomedical drugs were administered. Prescriptions were never given to the patient and drugs were dispensed directly. Generally referred to as 'doctor sahib', some of these practitioners are known by their 'specializations', 2 of them in particular are known as 'injection doctors'.

While 12 of the 18 less-than-fully-qualified practitioners operate as full-time practitioners within the settlement, 6 of them run clinics in other areas of the city as well. All these clinics are located in low-income settlements. Seven of these practitioners supplement their income as health care providers with additional jobs - three of

them sell life insurance, two are provident fund agents, one is a newspaper agent and one has a small chemist shop near his house in neighbouring Masoodpur. Although involvement with associations is a closely guarded secret, 11 of the 18 less-than-fully-qualified practitioners admitted that they were members of an association which comprises informal practitioners in south Delhi. The research team was unable to collect any further information about this association.

4.2 Conducting business

The typical clinic in Midanpuri consists of a single small room unit (approximately 4 x 6 in size) which is partitioned by a green cotton curtain into a consultation area and a rear space just big enough to accommodate a wooden bench used for examining patients. None of these clinics were found to provide inpatient services.

The usual roster of equipment in the clinic consists of those that are considered to be "appropriate to the needs" of the less-

than-fully-qualified practitioners and generally includes a thermometer dipped in betadine solution (a topical antiseptic); a stethoscope, generally prominently displayed; and a sphygmomanometer or manual mercury manometer to measure blood pressure. One clinic even has an old non-functioning photocopier which is kept there "for effect" in the words of the unlicensed practitioner.

A majority of the unlicensed practitioners were found to keep their clinics open 7 days a week. They say this was a crucial factor since they were then able to "provide support to the community" through the week. The timings of the clinic were clearly designed to 'fit' the work schedule of the inhabitants of the settlement. On average, a neighbourhood practitioner was found to work through two main shifts, one in the morning (9am – 1 pm) and another in the evening (4 pm – 9 pm). Five of these practitioners who reside in the settlement were found to keep their clinics open the entire day to around 10pm. Maximum number of patients visit these clinics in the evenings. The 6 practitioners who operate clinics in other

parts of the city as well, have employed helpers who man the clinics during the afternoons when patient load is less. The helper either gives an alternative time for the patient to return and in case of an emergency he summons the practitioner to the clinic. There is no system of prior appointments and the patients are seen on a first-come-first-serve basis.

The neighbourhood practitioners were found to keep a ready stock of drugs. These drugs, they said, were purchased from chemist shops as well as medical representatives. This is an arrangement that is clearly beneficial to both players – the medical representative makes money for something that he is officially meant to provide to registered medical practitioners as physicians' samples and free of cost; and the practitioners buys these medicines at a much lower price than the prevailing market rate. While we recorded repeated hints of purchase of medicines from government outlets, only 4 of these practitioners clearly said that they purchased medicines from compounders who were employed in government dispensaries. Further details on the modalities of such transactions or the location of the dispensaries, etc. were not revealed.

4.3 The patient in the clinic

Almost all patients were from within the neighbourhood and a small number from construction sites and small settlements on the periphery of the settlement within walking distance of the clinic. The average patient load per day ranged between 10 and 25. There was seasonal variation with a higher number of patients recorded during the summer months.

Of the 471 clinical interactions recorded during observations in the clinics, three-fourths were acute conditions, predominantly fever (of indeterminate origin), cold, diarrhoea, asthma, cough, body pain, weakness, TB, skin problems, mental problems, sexually-transmitted diseases, injuries, and conditions reported as BP (blood pressure).

A striking number of abortions as well as many cases of repeated surgery after abortions were also recorded. Information on 39 different cases of diagnosed HIV/AIDS was collected from the private practitioners during the 2 years in the field; not a single case, however, was self-reported by the patient.

There was no system of registration and no records were maintained of the patients. Treatment was provided purely on an episodic basis. No evidence was found of either any inpatient procedures or deliveries conducted. Referrals to abortion clinics on demand, however, were very common. Immunization services were also not provided.

4.4 The clinical interaction

The interaction was usually short with the average consultation lasting no more than 3-5 minutes. There was an almost exclusive focus on curative care and 'what the patient wants'. The interaction usually began with a description of symptoms by the patient,

generally accompanied by direct pointing to the site of the afflicted. The patient was physically examined in 58% of cases; 42% cases medicines given sans any examination, either on basis of symptoms or on specific request. While it was common practice for the patient to sit beyond the actual consultation time and carry on an informal chat with the practitioner, interactions that focussed on providing an on-demand service were epigrammatic. Questions by the less-than-fully-qualified practitioner were brief.

> A couple, around their mid forties, walk into the practitioner's clinic. They greet him and sit on the bench near the practitioner's table. The woman says that she is suffering from acute pain on her back and that she 'want[s] an injection for the pain'. The man says that he has been suffering from high fever for the past 5 days and that he too 'needs' an injection.
>
> The practitioner wordlessly hands the man a thermometer and asks him to insert it into his mouth. While the man sits with the thermometer in his mouth, the practitioner takes out a vial and a syringe (which has evidently been used before) from inside the drawer of his table and injects the woman on her right upper arm. Then he takes out the thermometer from the man's mouth, says "102 degrees", takes out another vial from the same drawer, and injects the man. He uses the same syringe. The couple pay him Rs 60 and leave the clinic. The only sentence that has been spoken by the practitioner is the pronouncement of the fever. The consultation, which includes both patients, does not last more than six minutes.

Perceived strictly as a business, these practitioners seem to have an exacting assessment of the prevailing market forces, and deliver accordingly. If patient interest centred around medication, the focus was explicitly on the medicines alone; if the patient questioned the practitioner 'why' a problem had occurred, references would be made to environmental factors and diet. No references to side-effects were recorded in any of the clinical interactions.

Although the duration of the actual clinical interaction in a majority of cases was short, it was often found to go beyond a two-way communication to exchange information; in many cases it appeared to be a product of the networks in which both the actors functioned in this particular context. The atmosphere in the clinic was always relaxed. Continuing conversation with other patients waiting to be seen or with the companion accompanying the patient was common. Often, the conversation would meander to discussions about the current political climate and issues concerning the settlement and their life situations. The relationship with the local practitioner is clearly situated amidst the larger social sphere which both the patient as well as the practitioner inhabits.

Private practitioner 1: 7 cases of fever observed during 2 consecutive sessions
Private practitioner 2: 21 cases of body ache and 'weakness' during 3 consecutive sessions

In both clinics, injections are administered. In all cases, the private practitioner uses a disposable injection, and after he administers it, puts the injection back into the plastic packet and reuses the same on the next patient.

When the researcher questions the private practitioners about re-using (disposable!) injections:
Private practitioner 1: *the hype over disposable injections is being generated by the media in conjunction with the 'english company' [manufacturers] to increase sale of these injections. 2 male patients present at that time agree with the private practitioner.*
private practitioner-2: *Was there AIDS when they had no plastic injections? In the olden days nobody died of using the same injection...so it is a myth....*

11 patients in the clinic agree. They say that *angrezi* ["english"] doctors use these tools as an excuse to charge more fees from them.

In a discussion with one of these practitiones on the huge demand for injections by patients, and on the appropriateness of administration of injections when they are not required, he unabashedly declared '*...in any case, if I don't give it, some other doctor will... so what difference does it make...?'*

All practitioners were found to reiterate the patient's point of view. As another unlicensed practitioner succinctly put it:

It is like this....when a patient wants something, you have to give it. After all, he is the one who is desperate to get well, isn't it. So if he comes and asks me for injections, why shouldn't I give it? It is all up to him. In this business, you have to do what the patient wants... After all he is the person who is paying, isn't it...?

4.5 Dispensation of drugs

Patients were often found to directly request medicines for specific ailments such as *tension ki goli* (tablet for tension), *neend ka goli* (sleep tablet), *pet ki goli* (stomach tablet), *dard ki goli* (pain tablet), *khasi ki goli* (cough tablet), or *daat ki goli* (teeth tablet) as Kamat and Nichter (1998) found in their study in Mumbai. Similarly, there was a large demand for injections, and most often would be referred to as *dard ki injection* (injection for pain). The demand, as one of the oldest practitioners in the neighbourhood succinctly summed up, is invariably for "high powered medicines".

The practitioners were found to always give clear instructions on how to "take the tablets". Loose medicines are explained in detail according to colour, size and shape and doses are prepared into *pudiyas* (small individual paper packets). Generic descriptions are provided with medicines being specified as "for heart", "for bones", "for tension", "for sadness", "for BP" Doses are usually given according to the amount of money in hand. The sale of partial

doses of medicine was cited as a huge boon for the majority of patients who are dependent on daily wages. If money was not cited as a constraining factor, doses were usually given for a duration of two days with instructions to the patient to return after the dose got over. Although in approximately one-third of the cases, loose medicines without a counterfoil were given which made it difficult to assess each category, it was possible to determine that these medicines were largely antibiotics, painkillers and tranquilizers. The injections were largely administered with corticosteroids.

The WHO (1998) defines rational drug use when "patients receive medications appropriate to their clinical needs, in doses that meet their own individual requirements for an adequate period of time, at the lowest cost to them and their community". Although making a prescription audit was beyond the mandate of the study, observations in the clinics of private practitioners demonstrated that there was an excessive use of antibiotics and injections by both groups. While injections for pain, tranquilisers, multi-vitamins and pain killers were the main choice among the less-than-fully-qualified practitioners, antibiotics emerged as the most common category of medicine among qualified private practitioners. Of the 37 prescriptions recorded in the qualified private practitioners' clinic, 32 prescriptions contained at least one antibiotic. While both categories used anti-tuberculosis drugs, none of them observed the Directly Observed Treatment, Short Course (DOTS) strategy. None of the unlicensed private practitioners had any knowledge of the national TB control guidelines while the qualified private practitioners said that they did know of the guidelines but "did not have the time" to "follow" them.

Virtually all prescriptions in the 471 clinical interactions had multi-drug combinations. For example, the most common combination of drugs from those listed in Table 1 were antibiotics, analgesics and multivitamins.

Table 1. Categories of drugs perscribed

Drug category	% of prescriptions
Antibiotics	90
Multivitamins	72
Anti-inflammatory and analgesics	68
Topical antifungals with cortico-steroids	65
Injections with corticosteroids	63
Tranquilizers	61
Anti-diarrheal	54
Anti-tuberculosis	38

4.6 How do they diagnose?

Notwithstanding the veracity of their degrees, short-term diplomas in Indian Systems of Medicine give the less-than-fully-qualified practitioners a basic knowledge of human physiology. Further, they draw upon experience garnered from their previous work in quasi-medical and medical settings as chemists, and helpers in doctors' clinics and hospitals/nursing homes.

Many of them were found to keep themselves abreast of current press releases on current public health issues. During the summer of 2004 when there was an outbreak of meningitis in the capital, several practitioners had newspaper clippings in their clinics to guide their diagnosis of patients. Similar clippings on outbreaks like dengue were also used.

We found that often these practitioners would receive patients who have already consulted other qualified medical practitioners and visit them for follow up consultations. It is common practice for the less-than-fully-qualified practitioners to scrutinize

prescriptions given by these practitioners and dispense the same set of medicines. Many of them retained these prescriptions and administered the same cocktail of drugs to other patients who reported similar symptoms.

Almost all the practitioners we interviewed spoke of aspirations to "become better doctors". They evinced an eagerness to participate in workshops and be part of national programmes run by the government. The research team was constantly asked, particularly towards the end of the project, whether they would assist in training them, or in acquiring higher skills.

4.7 Fees

The payment system is different for the two categories of private practitioners. While the qualified practitioner charges a flat fee of around Rs 50, the less-than-fully-qualified practitioner's payment system is flexible and ranges between Rs 20 and Rs 40, depending on the amount of tablets or injections administered. The less-than-fully-qualified practitioners insist that there is no consultation fee and they charge only for the medicines. The reality, however, is that the consolidated amount of money that is charged includes consultation as well as the medicines. Notwithstanding the actual breakup, fee levels are kept low but ensure that there is some profit after paying for capital costs.

It is difficult to estimate the exact income of a less-than-fully-qualified practitioner as it depends entirely on the number of patients which varies across seasons. On an average he earns around Rs 6000-7000 (approximately USD 125-145) per month. He describes himself as a "poor man's doctor" who earns "just enough to support (his) family of four" and to live a "somewhat respectable life". A majority of them, as we have seen earlier in the report, have found ways to increase the number of 'services' that they perform. Home visits are considered to be lucrative with the charge to the patient

being about 10% higher. Patient contact is high and over time, patients are found to be dependent on specific less-than-fully-qualified practitioners. No doubt the business is lucrative enough for the number of clinics to have increased almost twice in a two year period.

Economic, personal and social incentives to work drive these practitioners to set up clinics in the area. "Service to the community" and "to serve the poor" are the two main reasons given by the unlicensed practitioners for setting up practice in the area. They all said that they gained substantial satisfaction from their practice despite the fact that they wished that the financial rewards could be higher.

4.8 Responding to crisis

The absence of qualified doctors in the slum is a common ground for argument in favour of the unlicensed practitioners' presence in the settlement by both themselves as well as the inhabitants of the area. An unlicensed private practitioner said:

> *People want to assign blame, and it is better to target doctors like us... even big doctors make mistakes...how many times is that reported in the media? There is no point holding a knife....having great degrees....the main thing is - are they* [the qualified medical doctors] *here* [in the slum]*?*

While the private practitioners in Midanpuri justify their practice on the grounds that there is "a lot of reputation" involved in being addressed as "doctor sahib" and that "being a doctor" in the area means lucrative business, they are in a situation of crisis. On the one hand is the imminent threat of eviction if the slum is demolished, and on the other are raids that are conducted by the authorities to close down the clinics of these unregistered practitioners. Both threaten long relationships with the residents of the slum forged

over the 10-15 years that they have been practising here. Contingency plans have, therefore, been made by several of these practitioners. As one of unlicensed private practitioners said:

> *If I have to close down my clinic, I will suffer heavy losses. I have to look for a place to set up my practice again and that is not easy. But I am not afraid. All this demolition means that there are thousands of people who will be homeless in this big city, their children will fall ill, they will be a moving population, without any amenities ...the government will be forced to provide big colonies for them... and that means that there will be more and more demand for doctors. So I have planned in advance... I will set up practice in a big resettlement colony. My business will be better than now, I am sure of that...*

Raids conducted by the authorities make them nervous but they seem resolved to fight this state of crisis. In fact, the negative social conditions in Midanpuri seem to actually serve as challenges to bring about a stronger sense of perceived self-efficacy and self-confidence.

> *The angrezi* ["English"] *doctors form a powerful lobby. They are the ones who instigate these raids.... They feel that we are stealing their practice. They know that we are the ones who are most popular in the jhuggis so they want to stop us, close down our clinics...but we will not let them. We have our own associations, our own groups. And whenever any of us from the group is in trouble, we help each other out. Whenever there is trouble like this, we get more determined that we will not let anybody stop our practice...*

This term – 'english doctors' – was commonly used by these practitioners to refer to medically qualified doctors.

4.9 Less-than-fully qualified practitioners vs. qualified practitioners

The 7 qualified practitioners, all biomedical doctors with basic MBBS degrees in Medicine, that participated in the study are located outside the settlement but within a radius of 3-4 kilometres of the neighbourhood. They run very busy small one or two-room clinics in very crowded market hubs. In contrast to the practitioners located inside Midanpuri, these clinics have large boards with the name of the practitioner, followed by a long list of medical qualifications marked by acronyms and their registration numbers. The research team was unable to fathom full forms of qualifications, other than MBBS, in four cases. A list of specific conditions (treated successfully by these practitioners) was found written on the boards in 5 of these 7 clinics. A majority of these boards are bi-lingual with writing in both Hindi and English. While 3 of these practitioners are attached to chemist shops, 4 have independent clinics of their own. With an average patient load of 15-35 per day, all these practitioners do brisk business. Conversation with the patient is minimal and is restricted to a brief narration of symptoms followed by a physical examination. While male patients are most often examined in the presence of other patients who wait their turn, female patients are almost always examined behind a screen. Clear networks to neighbouring diagnostic centres (pathology laboratories and X-ray clinics) could be discerned. They were seldom found to recommend diagnostic centres that are located elsewhere.

Identified through patient narratives, these practitioners were difficult to interview due to their very busy schedules and interviews, when conducted did not last more than 15 minutes each time. Observations by research staff were also limited to an hour at most at each of these clinics. The main reason they gave for resisting the presence of the researcher during clinical interactions was distraction that this posed to their patients.

The difference in the prescriptive behaviour patterns between qualified private practitioners and the less-than-fully-qualified

practitioners on first consultation was found to be marginal. The only major difference was that among the former, a prescription is written out and a flat consultation fee is charged while the latter group dispenses medicines and charge a variable fee that includes consultation as well as medicines administered by the practitioner himself. Other parameters that were taken into consideration while comparing the two groups of practitioners include duration of consultation, number of questions asked, physical examination of the patient, referrals to both public and private facilities, and attribution of competence by the patient and/or caregiver. A final variable that was used from the initial days of observation of the practitioners was the level of variation, if any, in the practitioner's knowledge (as recorded during interviews) vis-à-vis his practice in the clinic (as recorded during observations of clinical interactions).The caveat here is the small number of qualified private practitioners in comparison with the larger group of less-than-fully-qualified practitioners. This following therefore would serve more as interim rather than conclusive observations.

Table 2 below summarizes the main findings in a comparison of qualified doctors and less-than-fully-qualified private practitioner for fevers (undetermined), cough and cold, diarrhoea, vaginal

Table 2. Qualified vs. Less-than-fully-qualified practitioners

Variables	Qualified	Less-than-fully-qualified
Time spent	Less	More
Questions asked	Less	More
Physical examination	Less	More
Evaluation of competence by patients	Higher	Lower
Referrals to government hospitals	Less	More
Referrals to private hospitals	More	Less

discharge and TB. While large discrepancies between what they knew and what was actually observed in the clinics was found in both groups of practitioners, the variation seemed to be larger among the group of qualified practitioners studied.

Referrals to diagnostic facilities for X-rays and blood testing were common in both groups. However, while networks between the qualified practitioners and diagnostic facilities in neighbouring Munirka and Mahipalpur were clearly discerned, this was not the case among the less-than-fully-qualified practitioners. There were very few referrals to other (qualified/ medical) doctors among both groups. Referrals to government-run hospitals were more marked among less-than-fully-qualified practitioners than among the qualified doctors. However, most of these referrals are made in acute conditions after at least 4-5 visits to the practitioner. In a majority of the cases, the conditions seem to have deteriorated significantly by the time the referrals were made. Clearly, delayed referrals driven by a fear of losing the case among these practitioners are a matter of urgent concern. Wrong diagnosis and delayed investigations leading to either wrong or delayed treatment with the attendant complications pose a serious threat to the lives of the patients.

5.

Why Private Practitioners?

Access

As we have seen in section 3.2.4 of the report, access – both physical as well as social access – determines the choice of practitioner for basic primary care. At the time this report is written, there are around 4 clinics in every block in the neighbourhood. The obvious benefits associated with having a medical help at hand propel choice, even if the people are aware that they might not possess the 'best' qualifications.

As one of our key respondents, said:

> *Of course they are not big doctors. But how is that important? Will a big doctor set up his clinic here? There are 25,000 people and no* [government] *dispensary. So what do we do? Wait for these big doctors to come and save us....? At least these doctors are here when we need them, and they know about medicines...they are good enough for us...*

Versions of the same sentiment were recorded time and again throughout the duration of fieldwork. Thus, despite the much wider variety of options in an urban setting, access of the poor to qualified health care practitioners is severely compromised by their socio-economic status and private health care providers, especially the local practitioners, are invariably the practitioners of resort.

Stigma

While proximity means that they consult a practitioner who is close at hand, in stigmatized conditions like TB and HIV/AIDS in particular, and even for sexually transmitted infections, while the

preference stays clearly with the private sector, they were found to opt for clinics which were at some distance from where they live. Issues concerning privacy during consultation and the attention received in these clinics were recurrent themes in their narratives. References to social stigma associated with TB appear to continue to dominate their lives despite communication efforts by the Government to reach out to the masses.

> *Neighbours, friends, the house where I work...do you think they will be the same if they know I have TB? They will all treat me like I am a keeda* [insect]*....if I have to continue to live with dignity then nobody should know that I have TB...*
>
> - 42 year old male, Midanpuri

In almost all the cases of TB that we encountered, even in cases where the patient may have undergone DOTS treatment at some point in time, there was a clear preference for the private sector despite the location of a government TB hospital within a 5 km distance of the slum.

> *When people from here see me going to a TB hospital, they will know that I have TB. Then I will have trouble. In fact, one of my neighbours, he lives in C block, was waiting in the bus stop of the hospital when I got off the bus one day. He saw me that I was going to the hospital and he came and told everyone here that I have TB. I have 4 unmarried daughters. If they spread the rumour that I have a disease that spreads, who will marry my daughters?* [Bends closer towards me] *Actually one of my daughters, Sarita, has symptoms. I have not taken her to the TB hospital because other people will see her there. She may not have TB but also maybe she has. But I took her directly to Singh clinic. He is treating her now. He has given her a full course...some kind of strong antibiotics. He also gives her injections sometimes when she gets fever...*

A 48 year old construction labourer, and father of four children said:

> *It is all right for the hoardings to be screaming about AIDS...you only know what happens when it happens to you. I got myself tested and they told me that I had AIDS. Only my wife knows...how can we tell other people? I have seen what happened to Gunaram* [his neighbour] *the moment his neighbours found out that he had AIDS...that was it! They don't even want to drink tea with him in the evenings....so will I risk my wife and my daughters in the locality...? In the public hospitals you go to the AIDS clinic, and everyone will know you have AIDS. Sooner or later somebody will see you there ...then it is all over...and these people in these* [government] *clinics...how they treat you....like diseased dogs in the street...like you are a criminal...so I prefer to go to the private doctor in Katwaria* [Sarai]*...at least I sit inside his clinic by myself, he talks to me properly and he gives me medicines...*

Time

For people subsisting on daily wages, time is a crucial factor as time, among other things, translates itself into wages; and wages as opposed to pay are won and lost on a daily basis.

> *We get harassed when we go to these big places... We have to go stand in queue early in the morning to get a parchi* [patient card] *done. Sometimes it takes many days to get just that done. And the doctors are so rude. They spend 2 minutes with us - just write names of medicines, we buy the medicines from outside. If we have to get tests done, wait endlessly to show the results. They don't even listen to us.... What's the point in all this?*
>
> - 37 year old male, Midanpuri

> *These sarkari* [government] *places are the last places where you must go. They are good if you need to have operation. Not much cost. But these things...at least a week ... And who can afford to lose wages for that much time.... That's why I come here when I am ill. Only to private...*
>
> - 40 year old male, Midanpuri

Whether it is time spent waiting in queue to get the *parchi* done; or time spent on getting the tests done or, on a completely different register, the amount of time the doctor spends with the patient: a time of care, attention and the possibility for playing out a moral drama as, at times, the seeking of a cure may be an end in itself. On all these counts, the dice obviously rolls in favour of *private* (physicians).

Competence

There is no one particular grid for defining competence of a practitioner and the list of capabilities was usually drawn from previous experiences with the same practitioner or personal testimonies of neighbours, friends or kin. Level of certification of the practitioner was seldom a deterrent to choice.

> *He may not have big degrees, may not speak good english, but is that important...? He knows what to do...has close to 20 years experience, he is better than many bada* [big] *doctors...*

Competence in public facilities was clearly considered higher but long distances to these facilities, circuitous and time-consuming registration procedures, waiting time, loss of wages and disrespect by the practitioner were deterrents. If one were to attempt a grading scale, the less-than-fully-qualified private practitioners were generally positioned third after qualified private practitioners. However, competence, as Jenkins (1998) has pointed out, is socially

constructed and ascribed. It is a many-layered concept. Variables like 'experience' were often used to calibrate these local practitioners, especially if they had an established and favourable relationship with him. Local models of competence were, therefore, context-dependent. As a 52 year old woman said empathically:

> *He knows. He said that he has seen many cases like hers. Many young girls in this locality have it I believe. So he does not need to see reports. He knows it instinctively. See it is also about experience...*

However, these classificatory boundaries were not always definitive, and often overlapped. These attributions were open-ended and constantly modified as the illness biography progressed. Hierarchy of competencies therefore were found to be arranged along notions of efficacy vis-a-vis what was perceived to work *under the circumstances* and what did not.

Quality of care

This "quick-fix, quick profit mentality" (Kamat and Nichter 1998) of the private practitioners is found to be stoically accepted by the patients. While many of the inhabitants of Midanpuri were aware of the fact that these *daktar* (doctors) do not possess the "right qualifications", and often they drew distinctions between a *bada daktar* ('big doctor') and "these doctors", they were at the same time convinced that these practitioners had "knowledge about medicines" and were a pragmatic solution for "ordinary" or "not so serious" conditions like fevers, body ache, stomach disorders and cough and cold. This concurs with Kamat's (2001) finding in his study of the role of private practitioners in the management of malaria in Mumbai, India, where patients were clear that they visited these practitioners primarily to "get medicines" and their expectations of these visits did not extend beyond finding an immediate reprieve to their problem.

However, in conditions that required more attention, maintaining dignity and confidentiality of the patient emerged as a recurrent theme. Narratives of care seeking for reproductive tract infections in particular were dominated by the need for sensitivity on the part of the health care provider. Reproductive tract infections are largely believed to occur among sexually-promiscuous adults. Thus, the need for discretion drove them to private practitioners who offered them a reprieve from the ridicule that they often faced in government hospitals. As a 33 year old woman summed up:

> *Everyone will say the same thing...there is nothing new in what I am saying. You go to a government hospital, you are treated like an animal...they treat you badly because they think you are a loose woman just because you are a poor woman and live in a slum. I was told by a staff in the* [government] *hospital as she wrote the names of medicines on the parchi, "first clean up your habits and then come back here for treatment". There were at least 30 people in the room with me. I felt like a dirty woman and couldn't look at the other women around me. Why should I ever go back there? Do they have a right to treat you like this just because you are poor...?*

Along the same vein, a 42 year old woman, diagnosed with TB, made a clear distinction between quality of care by a qualified doctor from Munirka, and a neighbourhood private practitioner:.

> *Dr X...see what he does...people say he is a big doctor, but he gave me tablets...I didn't even get well, and when I went back after 10 days, he says loudly 'you have TB, go get it checked'....in front of so many people and then calls out 'next' to the other patients*...The husband, during a subsequent interview, justifies the reason why the wife prefers to continue to consult the neighborhood practitioner instead. *When she visits him* [the neighbourhood practitioner], *he gives her*

injections, she is able to get back to work....his treatment is very good....and now whenever she feels sick she goes to him...he listens to her....understands. That is also important, isn't it...?

During a group discussion, the respondents emphatically said that they did not "get what [they] need in public facilities". They were almost always "made to run from department to department with long queues at each point". Indifference and a total lack of concern were encountered everywhere, especially from the clerical and other non-medical staff. Senior doctors were often not approachable and the younger, inexperienced doctors were brusque, generally did not listen to what the patient had to say and issued orders. Under the circumstances, there was an unambiguous preference for "better care" by the neighbourhood practitioners, who might be less-than-fully-qualified, in comparison to what they perceived to be inadequate care in a government facility.

6.

What is the Way Forward?

Cannot wish them away

Choices that the urban poor make for health care have implications not only for the individuals treated and the development of drug resistance but also for disease transmission to the wider population living in congested urban settings. While their recourse to the less-than-fully-qualified practitioners is of urgent concern, their use of the qualified private practitioners too needs attention. While the public health consequences of the inappropriate treatment protocols that the less-than-fully-qualified private practitioners use, and their misuse of drugs, is well known, arbitrary prescription practices and delayed referrals to appropriate facilities by qualified doctors pose serious threats as well.

Unlicensed practitioners very often are the only ones 'on the spot' to provide basic primary care to the approximately 25,000 people inhabiting slum settlements such as Midanpuri. Their piecemeal medication options, as we have seen in the report, are a boon for daily-wage earners; they seem aware of health epidemics and media campaigns around conditions like HIV/AIDS, TB and maternal care; and they clearly appear to treat patients with dignity and respect. What is evident, therefore, is that these less-than-fully-qualified practitioners fill an important gap between the poor perceived quality of public health services and the high cost of the "fully qualified" private health care. Under the circumstances, it could then be argued that they largely succeed in providing at least *some* health care at low cost where none other exists. In the absence of better alternatives, what does the poor person in a slum settlement do?

Police raids are not the answer. Local networks within the neighbourhood relay information about imminent raids and the private practitioners are often helped to 'close down' their clinics. The research team was witness to two such raids in the neighbourhood where signboards outside the clinics were hidden or pulled down and certificates with (fake) registration numbers hidden. After the raids were conducted, the practitioners 're-opened' their clinics and continued to practice from the next day. Thus, it makes more sense to find ways to involve, rather than outlaw them.

What then needs to be done?

Instead of policing, considerable scope exists for change both within the public sector as well as the private sector. No single strategy will work. A combination of measures would need to be put in place involving a diverse set of stakeholders.

Revamp the existing structure

Institutional shortcomings of the *public sector* obviously need to be urgently addressed. There should be more specific focus on more public outreach and making this outreach more responsive. Unless the existing system is restructured to ensure that it 'works', there is no point in replicating what exists.

Regulation and monitoring of the *private sector* is the most pressing concern. The private sector may be thought of consisting of three wings: (i) the fully-organized-and-fully-qualified; (ii) the fully qualified providers that operate in less than well to do neighbourhoods where the slum population too go; and (iii) the less-than-fully-qualified practitioners in the slum.

The fully-organized-and-fully-qualified sector consisting of the large network of institutions and individual providers need to be made more accountable to the public and monitoring is required for sustained delivery of quality health care. While the private sector

has been incorporated into the Consumer Protection Act (1986), it is unlikely to be effective on its own unless mechanisms to seek redressal are framed keeping the poor in mind. At present there is no legal accountability in the private sector. Few complaints are registered, if at all, so the police are unable to pin down defaulters. The legislative framework thus needs to be urgently revamped. Rational *drug prescribing* is an imperative that cannot be ignored. And all of these are equally applicable to the second category of practitioners as well, though monitoring them may not be as easy.

Making available state-of-the-art facilities at hospitals does not result in improved health outcomes. *Consumers* lack the institutional structure to seek redress as victims of malpractice or negligence. Thus, poor and vulnerable groups need to be properly mobilized to be able to take advantage of programmes designed for their benefit.

Make use of the informal private sector

While working with the organized private sector may be easier (at least on paper) the unorganized individual providers (which includes the fully qualified practitioners outside slums and the less-than-fully-qualified practitioners inside) which the urban poor frequent, would no doubt be difficult. The main challenge, therefore, is to bring the informal service providers into the overall public policy net. But since the less-than-fully-qualified practitioners are the 'backbone' of providing health for the urban poor, what we say below will largely have them in mind.

Training: The more complex the strategies, the more demands it will put on government capacity to deliver. A system could be devised whereby a special cadre of practitioners could be trained to deliver a select range of services. Since the less-than-fully-qualified practitioners evinced enthusiasm in acquiring higher skills and in participating in government-run programmes, they could be drawn in to provide specified tasks in difficult-to-reach populations in the slums. Lessons could be drawn from the multi-component

behaviour change strategy - INFECTOM (INformation, performance FEedback, ConTracting, Ongoing Monitoring) - developed by the BASICS project to improve case management practices of private practitioners in childhood illnesses (Chakraborty et al. 2000); in-service training for management of diarrhoea and acute respiratory infections by private practitioners in Mexico (Bojalil et al. 1999); and training shop-keepers to provide anti-malarial drugs in Kenya (Hausmann-Muela et al. 2003). It would be crucial, however, to maintain focus on accurately assessing training needs on an on-going basis and providing the necessary upgrading of skills.

Monitoring and evaluation: To ensure sustained performance, the State must evolve a policy for regular supervision to monitor and modify provider behaviour. The devolution of implementation authority and flexibility to district and field worker levels will allow the programme to be responsive to needs at the ground level.

Involvement of all players in the field: Involving NGOs and all providers in the field will make sure that work is not carried out in silos. It is particularly important to ensure that information from the field at the community level is fed back into the system to make programmatic decisions – this will make it possible to change the emphasis in any particular component, or area of coverage.

Above all – address the context

None of the above will work effectively unless complimentary measures are enforced to confront the local context in the slums. The determinants of slum health are too complex to be defined by any single parameter. Yet, they arise from a common physical and legal derivation that concentrates the ill effects of poverty, the population composition and dynamics, and the constraints they face because of their marginalization and exclusion from the formal

sector. All these underlying social and living conditions are critical pathways to improve health in the slums.

The promotion of health for the urban poor must, therefore, take neighbourhood-centred as well as person-centred approaches. It is crucial that the environment is analysed as the 'vulnerable world of everyday life' to devise slum-specific interventions. Unless basic amenities like housing, security of tenure, clean drinking water, sanitation and electricity are provided, there will be limited success in public health interventions. Income generation programmes within these slums will bring in security of income. Self-help groups and Community Based Organizations can be linked to NGOs that could undertake such initiatives.

Several urban poverty alleviation programmes have been framed by the Government and are being implemented for the urban poor (see box). But the effects of these programmes are not felt in Midanpuri. Thus, there needs to be a concerted effort in ensuring

Some schemes by the Government of India for the urban poor

- *Nehru Rozgar Yojana*: designed to provide employment to the urban unemployed and under-employed poor
- *Swarna Jayanti Shahari Rozgar Yojana:* in effect since 1997 and revamped in 2009, focuses on skill development, self-employment, wage employment and empowerment of the urban poor, with focus on women
- *Jawaharlal Nehru National Urban Renewal Mission*: the largest national urban initiative focussed on urban infrastructure and governance and provision of basic services to the urban poor
- *Rajiv Awas Yojana:* new scheme recently announced by the Government for slum dwellers and the urban poor which aims to provide support to states that are willing to provide property rights to slum dwellers.

that the various schemes within the public sector are accessed and utilized for the entire family.

Appropriate interventions and treatments are only effective once provided in the context of accessible and utilized health care services. If increased uptake is a policy aim, making good quality care available and accessible should be the top most priority.

7

Recommendations

- *Ensure basic services* in slums, in particular, water, sanitation, drainage, and housing

- *Mapping*: Slum specific interventions should begin by taking each region in a city and collecting data and analysing the health status as baseline information; all health-related services (all private practitioners, types and kinds of practice) need to be mapped and in-depth information on client satisfaction needs to be collected

- *Set up responsive facilities*: Unless health facilities are responsive to the requirements of the urban poor, there will not be optimal utilization of its services and the existing ambivalence towards government institutions will continue. This could be achieved by allocation of qualified doctors in all under-served areas, perhaps through a compulsory student roster like out-patient wards in hospitals, and regular mobile clinics in slums. Medicines should be readily available

- *Train less-than-fully-qualified practitioners* to provide basic primary care and to recognize and refer complicated cases to government facilities. Clear definition of parameters for enrolment, standard treatment guidelines and care protocols need to be framed to define the exact nature of their functions

- *Evolve referral protocols* and service delivery linkages at all levels of care for all kinds of ailments. This will prevent overcrowding of public hospitals for conditions that can be treated at urban health centre level

- *Evolve a monthly surveillance system* to monitor the practices of the private practitioners that they are not providing healthcare outside their training as well as to monitor the quality of services provided in the public health facilities

- *Evolve micro-planning strategies and enable community participation.* A consultative approach involving all stakeholders - NGOs, self-help groups, local private practitioners - will determine what is best in a specific context. Slum level committees (with representations from both males and females and adolescent groups) should be formed to plan, take ownership of, and monitor programmes. Community collectives will also ensure access at the household level

- *Public awareness campaigns* should focus on educating consumers about inappropriate treatment protocols like re-use of disposable syringes and to provide feedback to public authorities

- *Integrate programmes* that deal with communicable diseases with urban health programmes; *integrate coordination between various service providers* such as the state health department, Urban Local Bodies, Integrated Child Development Scheme, the Swarana Jayanti Shahri Rozgar Yojna scheme for construction workers, and NGOs

- Create *community based insurance schemes*. A separate health insurance scheme for the urban poor under the National Urban Health Mission will ensure that health care payments do not exceed their ability to pay

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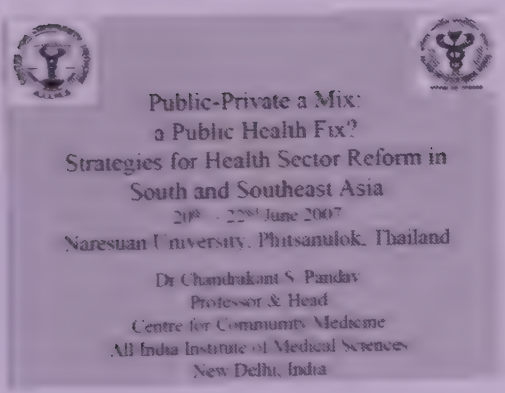
Annexures

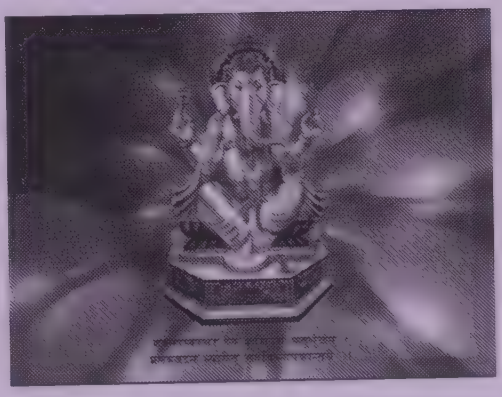
Annex 1a: Presentations by the Delhi project team

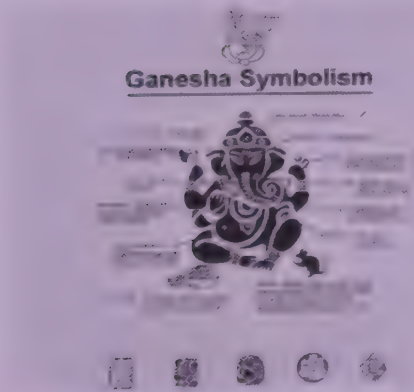
Public-Private a Mix: a Public Health Fix?
Strategies for Health Sector Reform in South and Southeast Asia

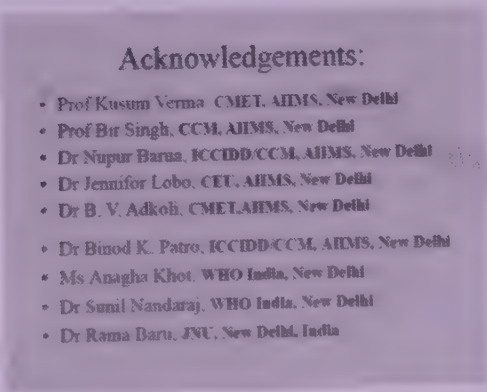
Naresuan University, Phitsanulok, Thailand
20 – 22 June 2007

Dr. Chandrakant S. Pandav









The call for action

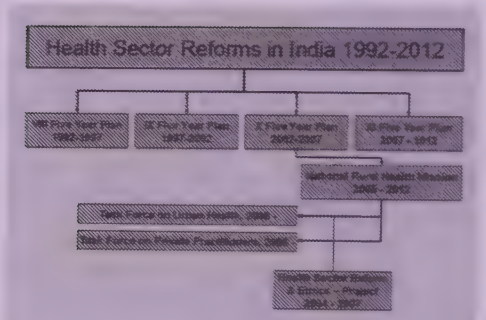
on health for the urban poor

Evidence for Policy

Outline of Presentation

- Health Sector Reforms in India
- National Rural Health Mission
  - National Urban Health Mission
  - Task force on accreditation, training and integration of Private Rural Medical Practitioners
- Health System Reform and Ethics

Private Practitioners in Poor Urban Neighborhoods in India, Indonesia and Thailand



Health Sector Reforms in India

1. **Deoki Nandan** – *Private Sector in the context of the National Rural Health Mission*
2. **Siddarth Agarwal** – *Urban Health Task Force Recommendations*
3. **Siddarth Agarwal** – *Public Private Partnership for Improving Health of the Urban Poor – Lessons and Best Practices from India*
4. **Ashok Kumar** – *Regulation of Medical Practitioners in India*
5. **Jeuffer Lobo** – *Regulation of Medical Practitioners in India*
6. **Rama Baru** – *Structure & Quality of Private Health Services in India*
7. **Nupur Barua** – *The discreet charm of private practitioner: Access, utilization and quality of health care in a slum in Delhi*

Outline of Presentation

- ***Health Sector Reforms in India***

Health Sector Reforms (HSR) in India

No consistent and universally accepted definition of what constitutes Health Sector Reforms thereby leading to varied meaning and connotations.

Moral

Brought in theologic wars. The disputants, I ween,
Rail on in utter ignorance, Of what each other mean,
And prate about an Elephant, Not one of them has seen!

Health Sector Reforms (HSR)

- "Sustained purposeful change to improve the efficiency, equity and effectiveness of the health sector"

  – Peter Berman (1995).

- "Defining priorities, refining policies and reforming the institutions through which those policies are implemented"

  (Lassels (1997)

Health Sector Reforms (HSR)

HSR deals with

- Equity
- Effectiveness
- Efficiency
- Quality
- Sustainability
- Defining priorities
- Refining the policies
- Reforming institutions for policy implementations

Health Sector Reforms in India

- Started in early 1990's
- India's reform measures are piecemeal and incremental
- Gradual shift in the organization, structure and delivery of health care.
- Three phases
  - VIII Five Year Plan: 1992 - 1997
  - IX Five Year Plan: 1997 - 2002
  - X Five year Plan 2002 - 2007

HSR in India – Eight Five Year Plan (1992-97)

- Concept of free medical care was revoked.
- Levying user charges for people above poverty line for diagnostic and curative services.
- Ensured commitment for free highly subsidized care for the needy BPL population

HSR in India – Ninth Five Year Plan (1997 - 2002)

- Convergence between public, private and voluntary health care providers.
- Increase involvement of voluntary, private and self-help group in the provision of health care
- Enabling Panchayat Raj Institutions (PRI) in planning and monitoring health programmes.
- Greater emphasis on accountability inter-sectoral coordination and utilization of local & community resources.

A Policy Analysis of the Health Sector Reform Process in India

Dr Rama Baru
Associate Professor, JNU
India Habitat Center, March 7th, 2003

A Policy Analysis of the HSR process in India

- The overall objective of this study is to explore the perceptions and experiences of health sector reform at the national level
- It specifically explores the definition, content, process, and sustainability of the health sector reform process in India.
- It seeks to understand both the internal and external forces that are shaping the health sector reform process.

Major Issues

- Definition incremental not fundamental
- The project approach to health sector reform
- Spaces are available for negotiations at both the central and state levels with multilateral agencies
- Since nearly all state governments are facing a fiscal crisis and health is not a high priority area of investment, most of them have been applying for loans to the Bank
- The interviews suggest that the entire reform process is a 'top down approach'. There is little consultation with the personnel at different levels of the health

Major Issues

- There is very little co-ordination among donors on health sector reform. There are situations where two or three donors are operating in the same state with their own priorities and agendas. This has raised the problems of duplication and ethnocism when it comes to programme implementation
- In the RCH programme the government has adopted the 'Rights Based Approach' after ICPD but this has not been effectively transferred to the different levels of providers
- 'New budget'

Health Sector Reforms

Ministry of Health & Family Welfare, GOI – WHO Initiatives

Sunil Nandraj
National Professional Officer
World Health Organization
Country Office - India

Initiatives

- Systematic review, documentation & analysis of health sector reform initiatives in India
- Providing a forum for enabling experience sharing at the Centre, across States and the Centre & States
- Identification of information gaps & conducting studies on HSR so as to provide evidence to policy makers & other stakeholders

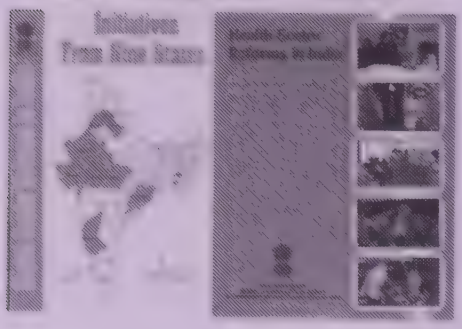
Process

- Review of literature
- Mailed Survey
- Interviews with Centre & bi-lateral & multi-lateral agencies
- National level workshop (Sept. 2003, Delhi)
- Visit to States
- Dissemination workshops

Areas of HSR

- Public Private Partnership
- Decentralization
- Human Resources
- Financing Methods
- Re-organization & re-structuring of existing system

Initiatives from Nine states – 2003 – 2004
HSR in India – II (Eight states) - March 2007



HSR in India – Tenth Five Year Plan (2002 - 2007)

- Reforms focused on primary, secondary & tertiary health care level.
- Emphasis was on equity and financing health care
- Social Health Insurance for BPL population – Universal Health Insurance Scheme
- ***National Rural Health Mission.***

Outline of Presentation

- ***National Rural Health Mission***
  - ***National Urban Health Mission***
  - ***Task force on accreditation, training and integration of Private Rural Medical Practitioners.***

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन
(2005-2012)

National Rural Health Mission: (NRHM)

- **Deoki Nandan**
  Private Sector in the context of the National Rural Health Mission.

Outline of Presentation

- *National Urban Health Mission*
- *Task force on accreditation, training and integration of Private Rural Medical Practitioners.*

National Urban Health Mission?

- **Urban Health Task Force also convened to addresses:**
  - Issues relating to health care for urban poor
  - Increasing number of private practitioners in urban centres
  - Options for public private collaborations

National Urban Health Mission
– just announced!

National Urban Health Mission

- **Siddarth Agarwal –**
  Urban Health Task Force Recommendations

National Urban Health Mission

- **Siddarth Agarwal –**
  Urban Health Task Force Recommendations

National Rural Health Mission (NRHM)

- Special focus on private health care providers
- Task Force formed for development of system for accreditations, training & integration of private Rural Medical Practitioners
- Centre for Community Medicine (CCM), AIIMS is part of the Urban Health Task Force & above

National Rural Health Mission (NRHM)

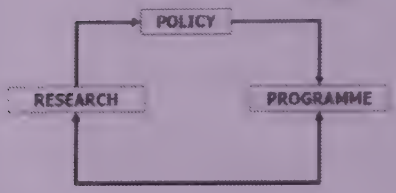
- **Rama Baru –**
  Structure & Quality of Private Health Services in India
- **Ashok Kumar & Jenifer Lobo –**
  Regulation of Medical Practitioners in India
- **Siddarth Agarwal –**
  Public Private Partnership for Improving Health of the Urban Poor –
  Lessons and Best Practices from India.

Outline of Presentation

- ***Health Sector Reforms in India***
- [illegible]
  - National Urban Health Mission
  - [illegible]
- [illegible]

ITERATIVE LOOP

Research, Policy, Programme



Health System Reform and Ethics:

Private Practitioners in Poor Urban Neighborhoods in India, Indonesia and Thailand

- Among very few studies in India which provide such intensive data on the role of private health care providers in slum areas
- Certain very important findings have been documented during fieldwork
- Findings have immense importance vis-à-vis current developments in the Ministry of Health & Family Welfare, Govt. of India

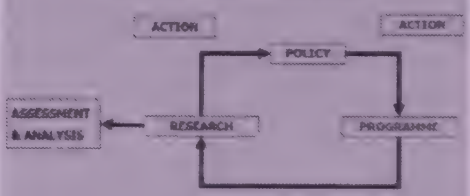
Health System Reform and Ethics:

Private Practitioners in Poor Urban Neighborhoods in India, Indonesia and Thailand

- **Nupur Barua –**
  The discreet charm of private practitioner: Access, utilization and quality of health care in a slum in Delhi

ITERATIVE LOOP

Research, Policy, Programme



Beyond the rhetoric…

- We have created the context
- The project could provide crucial insights for both these groups
- NOW, it is time for action

In Summary….

- Health Sector Reforms in India
- National Rural Health Mission
  - National Urban Health Mission
  - Task force on accreditation, training and integration of Private Rural Medical Practitioners.
- Health System Reform and Ethics: Private Practitioners in Poor Urban Neighborhoods in India, Indonesia and Thailand

The call for action

on health for the urban poor

Evidence for Policy

Annex 1b: Presentations by the Delhi project team

Medical Malpractice in India – Is Regulation the Only Solution?

Naresuan University, Phitsanulok, Thailand
20 – 22 June 2007

Dr. Jenifer Lobo

Medical Malpractice in India – Is Regulation the Only Solution ?

DR. JENIFER LOBO. MD
Consultant – ICCIDD
Centre for Community Medicine
All India Institute of Medical Sciences
Ansari Nagar, New Delhi – 110 049

Malpractice in all levels of health system :

- Public health provider
- Private practitioner
  - Registered Medical Practitioner
    - Allopathic Medicine
    - Indian Systems of Medicine (ISM
- Pharmaceuticals companies

Why is there malpractice despite the stringent regulations?

Lack of Implementation & Enforcement

- Numbers of health professionals
- Health expenditure

Why does the RMP indulge in malpractice ?

- Corruption

  OR

- Enabling factors in the system

Government based doctor indulging in private practice

- Financial needs
- Satisfaction in clinical work
- Family needs
- Future

Malpractice among private practitioners

- Requirements / needs of population
- Lack of knowledge
- Unwilling to update skills and knowledge

Private Hospitals

- Pressure from patients / family
- Consumer Protection Act.
- Insurance

Medical Malpractice in India – is regulation the only solution ?

Thank You

In the Pocket of the Private Healthcare Sector: Private Practitioners in Poor Urban Neighbourhoods in India, Indonesia and Thailand

Global Forum for Health Research 10, Cairo: 29 Oct–2 Nov 2006

Jens Seeberg, Supasit Pannarunothai; Chandrakant S. Pandav; Soenarto Sastrowijoto; Laksono Trisnantoro; Retna Siwi Padmawati; Aumnuoy Pirunsarn; Nupur Barua; Angkhanaporn Sornngai; Nur Azid Mahardinata

Worldwide, it has become increasingly difficult to maintain existing health systems, meet increased demands and improve the quality of care based on government funds alone. Many countries in Asia have adopted a strategy of expansion of the private health sector, and various attempts to establish public-private partnerships have been tried to ameliorate adverse consequences for the needy. However, existing studies suggest that better-off patients benefit more from public healthcare, whereas the poor segments may be left with the private sector as the only option, especially in areas with no or limited access to public facilities, such as urban development areas and urban slums.

This paper presents a multi-site study carried out in urban slums in India (Delhi and Bhubaneswar), Thailand (Phitsanulok) and Indonesia (Yogyakarta). The study mapped illness and household expenses in selected poor neighbourhoods, followed individual illness episodes qualitatively at household level, and studied the practice of different categories of private practitioners through repeated clinical observation and qualitative interviewing during 18 months of fieldwork.

Findings showed large variations in the structure of the private sector, ranging from semi-anarchy to relative order. The structuring

of the private sector vis-à-vis the government sector, its relative heterogeneity in terms of medical plurality, the (lack of) transparency of treatment options and costs, and the local construction of medical competence among the communities all influence the extent to which the private sector plays a beneficial or harmful role for therapeutic treatment of the urban poor. The universal coverage scheme, implemented in Thailand, seems to have decreased the use of the private health sector in important ways, thereby reducing the risk of catastrophic illness. This finding is compared with the situation in the two cities in India, where the need to establish access to free or affordable health services of appropriate quality for the urban poor is dramatic; the situation in the urban study in Indonesia is found to be somewhere 'in-between' India and Thailand in terms of services, affordability and health and economic outcomes for the poor urban households.

The social construction of competence: An ethnography of a clinical encounter in a Delhi slum

EASA Conference on Ethnographies of Medical Encounters between Europe and Asia, Bristol: 18-21 September 2006

Nupur Barua

This paper is part of a larger study on health systems reform in poor urban neighbourhoods in India, Indonesia and Thailand, with three components to it: a longitudinal household study of disease burden and resort to treatment; a household economic survey; and a desk study of the existing regulatory mechanisms of private practice.

In most poor urban neighbourhoods the world over, health service is provided by 'nonqualified' medical practitioners. This is particularly so in the context of Delhi where these 'quacks' make regular headlines in the media in the aftermath of fatal accidents

caused by misdiagnoses, and the Delhi government conducts raids in an attempt to shut their 'clinics'. But the fact remains that most of these 40,000 'quacks' continue to practice, albeit in many cases in clinics that bear no signboards or placards. They have their own associations and they constitute the backbone of the 'health service' for the urban poor.

In the medical and social science literature these practitioners appear as 'quacks' and have over the years invited a growing body of criticism. While some of this literature suggests social and economic reasons for their existence and why patients resort to them rather than turn to qualified and often 'free' state-run institutions, little exists by way of an ethnography of the actual encounter between patient and practitioner in this context.

The present study uses ethnography of such clinical encounters to understand why poor patients resort to such practices and what ensues in such settings. The paper discusses the social construction of competence in a context with obvious inconsistencies and clear indications of a lack of understanding of conditions (like polio, for instance) and the use of diagnostics. Whether the prescription is medically correct or appropriate is moot. While the accent is clearly on client satisfaction, and pragmatic concerns of ensuring a continuing (and sustained) patient base are apparent, there are also larger issues involved - of perceived competence, knowledge and ability to perform 'as a doctor' in a provider-patient setting – that drive the practitioner to perform. Use of detailed narrative analysis shows that the practitioner's main concern is to ensure that the key actors involved are satisfied with the treatment. An ethnographically grounded understanding of the motivations guiding this treatment seeking behaviour and the dynamics underlying the interactions in these clinics is crucial. This is particularly so if there is to be a regulatory framework that would work to protect patients in poor urban neighbourhoods against iatrogenic events when utilizing the private health delivery system.

Doctors, Quacks, the Market and the State: Complexities of Unregulated Private Health Care in India

XVI ISA World Congress of Sociology, Durban : 23–29 July 2006

Jens Seeberg and Nupur Barua

A number of studies in urban India have suggested that better-off patients benefit more from public healthcare, whereas the poor segments may be left with the private sector as the only option because of the relative absence of urban primary health care. The private healthcare sector in urban India is, in practice, largely unregulated. It is characterised by pluralism of medical traditions and has a high degree of syncretism among them. Therefore, it can be difficult for patients to know which tradition a particular practitioner belongs to.

The current study was conducted among private practitioners in poor urban neighbourhoods of two cities of India, using a combination of ethnographic methods. Field work took place over a period of 18 months.

In the absence of effective regulatory mechanisms and given the plurality of medical traditions with very varied ethical frameworks, if any, no systematic quality control mechanisms were found in the urban private health sector in any of the two cities. In both cities, the market was the main regulatory mechanism based on strong competition that led practitioners to provide whatever services were in demand among their costumers. The urban poor, with little chance to understand the diagnostic and treatment options offered at a price, frequently demanded symptomatic relief that seemingly would solve their immediate problems, even when this was medically ill-advised. Yet, the private health sector was very differently constructed in the two cities. This paper discusses

important differences between the private health care sector in two cities in terms from the perspectives of the urban poor.

Narrative wholes and fragmented experiences of illness and healing in two slums in Orissa and Delhi

Megaseminar on Holism in Anthropological and Ethnographic Research
Hindsgavl, Denmark: 22-24 May 2006

Nupur Barua and Jens Seeberg

Illness constitutes a potential threat of crisis. In Midan Puri, a low-income slum settlement in Delhi, India, with an population size of around 15-20,000, illness is but an element of an ongoing crisis that is otherwise constituted by threats of eviction, and a daily battle to avoid sexual and physical abuse, economic exploitation and social exclusion. Most inhabitants in the slum area, located near one of the city's most affluent neighbourhoods, are wage labourers. In spite of the constant economic struggle, people pay for the services of private health facilities when they fall ill.

There are 15 private practitioners without medical qualifications, and 2 free dispensaries run by NGOs in the slum. There is no government health centre. Catastrophic illness is not uncommon. Importantly, the 'doctors' in the neighbourhood are also in crisis. Regular raids are initiated by the police to crack down on these perceived 'quacks'. Still, they constitute the only category of practitioners who operate clinics inside the neighbourhood.

In Beluam basti, Bhubaneswar, Orissa, where we are conducting a parallel study, the 2300 people living there are comparatively poorer. Illness is a very real and immediate threat, but the health system is markedly different. Government facilities tend to be a first choice of treatment, and private practitioners are either medical specialists, alternative practitioners or faith healers; the category labelled quacks in Delhi is practically absent.

How do we, as anthropologists, understand people's lives on the edge - therapeutically, economically and affectively - in a context of chronic crisis? Narrative analysis has been used convincingly as a tool of holism, i.e. to construct meaningful wholes out of fragmented and fragmenting experiences. This paper explores the narrative construction of illness and healing in a context of chronic crisis through the analysis of one case from each site, and discusses the role of different contexts for our understanding of health-related crises.

How to Develop a Pro-poor Private Health Sector in Urban India?

Global Forum for Health Research 9, Mumbai: 12-16 September 2005

Nupur Barua, Kusum Verma, Chandrakant S. Pandav

India has the second-largest population in the world and a rapid urbanization. Primary health care is largely absent in urban centres. In Delhi, with a population of 13 million, health service is provided by the private sector in most poor urban neighbourhoods. Most prominent is the burgeoning number of unregistered practitioners who are not formally trained in any system of medicine. Another level exists of medical doctors, who are legally qualified to prescribe biomedical treatment, but empirical evidence suggests that over-prescription of drugs and diagnostics and, in the case of the nonqualified sector incorrect and often dangerous treatment strategies give rise to serious iatrogenic health problems. Irrespective of the presence of free government institutions in urban areas, a startling majority of the poorest of the poor go to these practitioners as a first resort. Reasons for this preference include issues of access, perceived quality of treatment, affordability and convenient timings, as well as widespread mistrust vis-à-vis the public system. To a population for whom out-of-pocket expenditures

on health and complete lack of insurance cover pose debilitating shocks with every episode of illness, the inappropriate treatment regimes of the largely unregulated, albeit readily available, private sector have potentially dangerous consequences at both the individual and at the public health level. An ongoing multi-country and multi-disciplinary study on health systems reform and ethics in poor urban neighbourhoods suggests that there is scope for improvement. This paper identifies dangers in promoting public-private mix given the current status of the private health sector in urban India and discusses viable strategies to develop pro-poor urban health policies. It suggests strategies to strengthen ethical practice in poor urban areas and ways to involve the private sector, keeping in mind that the sector does play a crucial role for the Millennium Development Goals, and that this role can be both positive and negative.

Ethnography of a Clinical Encounter: The Case of a Private Practitioner in a Delhi Slum

Nordic Association for South Asian Studies
Workshop 7: Health, Globalization and Marginalization in South Asia
Århus, Denmark: 3-5 June 2005

Nupur Barua

This paper is part of a larger study on health systems reform in poor urban neighbourhoods in India, Indonesia and Thailand, with a primary focus on the ethics of private practice. In most poor urban neighbourhoods the world over, health service is provided by 'nonqualified' medical practitioners. In the medical and social science literature these practitioners appear as 'quacks' and have over the years invited a growing body of criticism. While some of this literature suggests social and economic reasons for their existence and why patients resort to them rather than turn to qualified and often 'free' state-run institutions, virtually nothing exists by

way of an ethnography of the actual encounter between patient and practitioner in such a clinical setting.

This paper attempts to argue that an ethnography of such a clinical encounter is both the crucible and the possible future basis for an understanding of why poor patients resort to such practice and, more importantly, what precisely ensues in such settings. This is particularly so in the context of Delhi where these 'quacks' make regular headlines in the media in the aftermath of fatal accidents caused by misdiagnoses, and the Delhi government conducts raids in an attempt to shut their 'clinics'. But the fact remains that most of these 40000 'quacks' continue to practice, albeit in many cases in clinics that bear no signboards or placards. They have their own associations and it is they who are the backbone of the 'health service' for the urban poor. Unless we come to grips with why patients go to them, and the precise modalities of the encounter between patient and practitioner, we will not be in a position to suggest any kind of reform other than platitudinous ones. It must be pointed out, however, that the ethnography of the clinical encounter is only one part of a larger study with three components to it: a longitudinal household study of disease burden and resort to treatment; a household economic survey; and a desk study of the existing regulatory mechanisms of private practice. While the emphasis in this paper will be on the clinical encounter between patient and practitioner, it is only in the light of the larger framework that this ethnography acquires salience.

Annexure 2: Workshop report, Thailand June 07

HEALTH SECTOR REFORM AND ETHICS

Public-Private Mix: a Public Health Fix?
Strategies for Health Sector Reform in South and Southeast Asia

International Workshop
20-22 June 2007

Naresuan University, Phitsanulok, Thailand

WORKSHOP REPORT

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WWW.HUM.AU.DK/HSRE

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List of abbreviations

AIIMS	All India Institute of Medical Sciences
ANM	Auxiliary Nurse Midwife (India)
ARI	Acute Respiratory Infection
AU	University of Aarhus (Denmark)
AYUSH	Ayurveda, Unani, Siddha and Homeopathy
BPL	Below Poverty Line
CBO	Community-based Organisations
CME	Continued Medical Education
Danida	Danish International Development Assistance
DHS	District Health Services/System
DKK	Danish Kroner
DRG	Diagnostic Related Group
FFU	Danida's Research Council
GMU	Gadjah Mada University (Indonesia)
GOI	Government of India
HSRE	Health System Reform and Ethics (Research project)
ICDS	Integrated Child Development Scheme (India)
IEC	Informaiton, Education and Communication
LV	Link Volunteers
MandE	Monitoring and Evaluation
MCI	Medical Council of India
MoHFW	Ministry of Health and Family Welfare (India)
MOU	Memorandum of Understanding
NGO	Nongovernmental Organisation
NRHM	National Rural Health Mission (India)
NU	Naresuan University (Thailand)
NUHM	National Urban Health Mission

OPD	Outpatient Department
ORS	Oral Rehydration Solution
PHC	Primary Health Care/Centre
PNC	Prenatal Care
PP	Private Practitioner
PPM	Public-Private Mix (or Public-Private-People Mix)
PRI	Panchayati Raj Institution (local government, India)
QMP	Qualified Medical Practitioner
RCH II	Second phase of the Reproductive and Child Health Program (India)
RMP	Registered Medical Practitioner (in India, may not be formally medically qualified)
RUF	(Former) Research Council of Danida
SEARO	South-East Asia Regional Office (of WHO)
SLI	Standard of Living Index
U5MR	Under-five Mortality Rate
UC	Universal Coverage Scheme (Thailand)
UHC	Urban Health Centre (India)
UN-HABITAT	United Nations Human Settlements Programme
USD	United States Dollar
WHO	World Health Organization

Introduction

This document reports the proceedings of a research-to-policy workshop that was organized as part of a multi-country cross-disciplinary research project on the private health care sector in urban poor neighbourhoods in India, Indonesia and Thailand, entitled "Health System Reform and Ethics: Private Practitioners in Poor Urban Neighbourhoods in India, Indonesia and Thailand". The project consisted of a combination of medical anthropological research among private (for-profit) practitioners and among people living in poor urban neighbourhoods; a health economics study among poor urban households and a desk study that assessed existing regulations and ethical guidelines in the three countries. The project period was April 2004 to December 2007.

A number of other studies in the past have shown that the role of the private sector can be problematic, perhaps even more so in India than in the other participating countries. At the same time, there has been a push of public-private partnerships. The workshop intended to discuss the rationale, the benefits and limitations and risks of this strategy. Even if there are examples of successful partnerships that serve sound public health purposes, such partnerships may not address the structural problems that establish effective access barriers for the poor. Based on research that provided a critical assessment of the role of the private sector the workshop should develop relevant strategies to address public health problems related to the role of the private-for-profit health sector. The overall purpose of the project was to identify viable strategies for strengthening ethical practice in the private healthcare sector in poor neighbourhoods through feasible and locally acceptable control mechanisms and other possible means. It was believed that this is only possible through a combined understanding of patients', private practitioners' and drug vendors' perspectives. Health ethics, in this connection, may be broadly understood as a consensus-based normative regulatory framework that primarily works to protect patients against iatrogenic adverse events when utilizing the health system. The existing scientific literature shows that a framework of this type is not in place, or is not working to the desired effect, in a number of countries in South- and Southeast Asia.

The project consisted of four sub-studies that complemented each other in order to give a detailed and multi-faceted understanding of the local health systems under study:

1) Existing regulatory mechanisms, including ethical codes and legislation with direct implications for general private practitioners: desk study
2) Health systems ethics among private practitioners: ethnographic sub-study
3) Family-level treatment and health-related decision-making: interview sub-study
4) Household survey: health economics sub-study

The project was funded by the Danida Council for Development Research (RUF, after 2006 renamed to FFU) with a budget of four million DKK covering a period of three years (2004-07).

Further information about the project is available at www.hum.au.dk/hsre.

The workshop

During 20-22 June 2007, a 3-day workshop was held at Naresuan University, Phitsanulok, Thailand, to disseminate findings of this and related research in the region and develop policy implications. On Day One, research findings and recommendations was discussed; On Day Two, the focus was on comparative perspectives across the participating countries; and on Day Three, country-specific policy recommendations were developed on the basis of the previous days' work. The workshop progamme is attached as Annex 1.

The objectives of the workshop were:

- To identify feasible regulatory mechanisms and strategies for the private healthcare sector to improve quality of care for the poor in urban India, Indonesia and Thailand
- To identify lessons learnt and best practices from health policy interventions for the urban poor in the three countries

Inaugural session

Professor Supasit Pannarunothai, Dean, School of Medicine, Naresuan University, opened the session. He stressed that this hospital provided services for the poor and worked with networking mechanisms throughout the community. The objectives of the workshop primarily addressed the need to improve quality of care for the urban poor. Participants came from six countries and constituted a fruitful mixture of policy-makers, researchers and practitioners.

President of Naresuan University, Mondhon Sanguansermsri, welcomed the participants. He stressed the role of Naresuan University as a progressive university that emphasised health ethics as a key issue and that valued international collaboration. He then wished participants a good meeting.

Jens Seeberg, Assoc. Professor, University of Aarhus, then delivered his introductory remarks. He noted that it was a rare opportunity for a research project to be able to organise this kind of research-to-policy meeting and he thanked Danida for funding the project and the meeting. He then took the audience back to an earlier WHO-project on ethics in South-East Asia that had led to the current project. A regional research group was gathered to focus on the private sector. He noted that the private sector encompassed more than private doctors, i.e. insurance companies, private medical colleges, production and distribution of drugs, and others. All these components, he said, are complex and require careful consideration. Moreover, there are many different types of health providers. He stressed the need to conceptualise competing health systems and raised the question whether we need to abandon the concept of system in this context and replace it with a notion of health networks. He pointed out that little research had been conducted on the private sector when the World Bank strategy to down-size government funding of health care had been launched in the late 1980s. Twenty years down the line we still had limited knowledge of private sectors. He asked, where is the trade-off in government funding to ensure quality of the private sector through stewardship versus investment in government sector delivery? He then introduced the workshop by saying that the first day was dedicated to presentations and discussions. Group work sessions would develop comparative

perspectives on the second day and the final day would formulate country-specific recommendations. He stressed the shared interest in public health among all participants and said that mutual and progressive learning would be a key outcome of this workshop. Dr. Seeberg ended his address by expressing his gratitude to the local organisers.

Special Guest of Honour, Dr Samlee Plianbangchang, Regional Director, WHO (SEARO), then delivered the inaugural address. He appreciated that the subject of public-private mix was being revisited. He said there is no fixed formula for public-private mix. It depends on the country context. The government alone may not be responsible for providing health care for the poor; government partnerships with the private sector were necessary to ensure accessibility for the poor, but steps were necessary to ensure access to affordable and quality services.

Dr Samlee said it was timely to revisit primary health care with a focus on the urban setting. If properly designed and implemented, private health care may help to close the gap that currently exists because of the lack of financial resources. He said that private health care must be initiated and promoted by the government to meet the needs of all. Primary health care is the protection of any population's health. In most cases, governments should have a scheme for the poor ensuring that they are insured. Private sector should also participate in the promotion of health in the community. He stressed that the health services are dealing with human beings and those involved must be awarded and fully equipped with the moral and ethical issues surrounding their responsibilities. Ethics is a challenge and there is a need to put ethics into practice. Medical practitioners should be role models for the young people and the next generation should ensure that the needs of the urban poor are met. Primary health care can reduce the illnesses of the poor and make all people healthier. Private sector can make a contribution in addressing primary health care. All people have the right to be free from all illnesses and primary health care should be practised not only at the primary, but also at the secondary and tertiary level. Dr Samlee ended his address by noting that the findings of this workshop would contribute to our understanding of the current challenges as well as best ways of addressing those.

TECHNICAL SESSIONS

DAY 1 (20 June 2007)

Health Sector Reform and Public Private Mix?

Chair: Supasit Pannarunothai

Rapporteurs: Jenifer Lobo and Yati Soenarto

Dr. Chandrakant S. Pandav, after invoking the blessings of Ganesh for the workshop, said that India reviews and plans its health policy at intervals of 5 years. In the 8th 5 year plan (1992), the first health sector reform became evident when the concept of free medical care was revoked while commitment for free or subsidized care for the needy (BPL) population was ensured. User charges were also introduced. The 9th plan looked at the convergence between public, voluntary and private participation in provision of health care, community participation, and accountability of the health sector. In the 10th plan, reform focused on primary, secondary and tertiary health care, and emphasis was on equity, financing of health care and social health insurance for the BPL population. The National Rural Health Mission was introduced and towards the end of the plan period the addition of the National Urban Health Mission was introduced, recognizing the presence of urban poor and the presence of private practitioners of all varieties in these areas.

Health service reform has as yet no accepted definition, Dr. Pandav said. This adds to the problem of initiating change. Two definitions which appeared usable were given: "Sustained purposeful change to improve the efficiency, equity and effectiveness of the health sector" (Peter Berman,1995) and "Defining priorities, refining policies and reforming the institutions through which those policies are implemented" (Cassels,1997).

Dr Pandav outlined Health Services Reform as dealing with issues of Equity; Effectiveness; Efficiency; Quality; Sustainability; Defining priorities; Refining policies; and Reforming institutions for policy implementation. The need for moving to action as soon as possible was stressed.

Professor Laksono Trisnantoro explained that Indonesia has no history of planned health system reforms. Certain facts were presented: public health expenditure was 25% of the total health expenditure; 75% was private finance; 75% of the income of government doctors was from private practice which was not allowed; there was no control with medical practitioners; there was inequitable distribution of health care; and there was collusion with pharmaceutical companies.
On this background, health sector reforms were triggered by three Acts: Decentralization Acts, 1999 and 2004, Medical Practice Act 2004 and Social Security Act, 2004. Prof Laksono said that the acts did not affect the health scenario as it was difficult to implement the acts to control the private and public practitioners. There was a disparity in the economic status of the specialist and the general practitioners. The inequitable distribution of health care continued. He said that the Social Security Act was a reactive intervention to protect the poor due to the nationwide economic crisis in 1997. Prof Laksono presented a scenario analysis, where the worst case scenario involved failure to implement the Social Security Act and simultaneous rejection of the Medical Practice Act. To reduce the risk of ending up with the worst scenario, he recommended the following: 1) a cultural approach should be implemented to change medical doctors' way of life; 2) regulation to control the private health care sector should be developed alongside with cultural change; 3) a mixed approach of welfare state and market-driven policy should be put on the agenda of health system reform.

Dr. Pongpisut Jongudomsuk initially introduced Thailand as a lower middle-income country. The health indicators of the country were better than average for this group except in terms of human resources for health. The proportion of the poor used to be very high - 42 percent of the total population in 1988 - but declined with the gradual economic growth in the country. The majority of the poor lived in the northeastern region while only a small proportion, 0.5 per cent, was in Bangkok. The Government had previously introduced specific schemes for the poor. These were a) Low Income Scheme for those below the poverty line, b) Fee Exemption Scheme for public health facilities and c)

Health Care Scheme as part of the PHC strategy. As a result of these schemes there were problems of unacceptable quality of care for the poor, discrimination and social stigma.
The Universal Coverage Scheme was launched in 2002 to ensure access to care as a basic right for the entire population. Since it was a comprehensive package, exclusions were minimal. The main contractor was primary care providers. Private providers could participate voluntarily, but problems between the public and private care providers did occur. Dr Pongpisut concluded that the Universal Coverage Scheme is a pro-poor scheme although its nature is universal coverage. Lower utilization of the rich may lead to relatively poor quality of service. Tax-based financing is recommended for countries with a large informal sector to achieve universal coverage. Primary care and district health system (DHS) favor the poor and a financing mechanism should be designed to strengthen their functions. Increased access to care of the population may threaten a health care system with limited human resources, and a drain of experienced medical doctors from the government to the private sector was already happening in Thailand.

Dr Firdosi Mehta showed that the present situation in the global control of tuberculosis (TB) had improved substantially. Prevalence of infection and death due to TB had decreased through the implementation of DOTS. The problem in Southeast Asia is coming under control through strategic planning for each country and appropriate action. Public-Private Mix (public-private, private-private, public-public) enable partnerships to be developed for delivery of care for TB control. Evaluation of PPM initiatives have shown that good treatment outcomes do occur. The benefits of PPM were enhanced quality of TB management and care, decreased financial burden, cost effectiveness etc. The functions of the public and private providers needed to be delineated in order to make this strategy work. The role of PPM in the control of TB could provide lessons for future policy in other areas of health. A detailed example of PPM helping TB control through DOTS was given, where the private and public providers and the TB program collaborated to ensure that DOTS was implemented.

Professor Reidar Lie stressed the role of basic ethical values and human rights to guide health policies. The right to health means that health care has to be accessible to all. Yet there was a realization that economically weak countries would not be able to ensure equal rights to health for all citizens. This gave rise to the fairly popular notion, promoted by the World Bank and WHO, that there was a right

not to comprehensive health coverage, but only to a basic or essential package. But it was essential that improvements in economic status of the countries should be reflected in changes in health policy. While the human rights framework could not be used to prioritize one specific treatment type over another, Professor Lie noted that a human rights framework for health sector reform was needed to give direction to policy development, since differential access to health care was intrinsically unjust and governments should be made accountable for overcoming such inequalities. He stated that one cannot accept a system that as a principle accepts that one group of people receive access to a higher level of services than other groups.

Quality of care and dynamics of the health system (Parallel Session A)

Chair: Dr. Pongpisut

Rapporterurs: Rama Baru and Jens Seeberg

Jens Seeberg's presentation was based on the findings of the study of private health care delivery in Bhubaneswar, Orissa. Dr Seeberg pointed to the rapid growth of the private sector during the 1980's and the role of the World Bank that initially promoted this growth more in order to downsize governments rather than based on evidence regarding the private sector. The downsizing of governments has created benign conditions for the growth of the private sector. While referring to the private sector, he said that a distinction needs to be drawn between the 'for-profit and non-profit' sectors. In the former there are both informal and formal providers. The formal sector not only consists of providers but also includes production, sale and distribution of drugs and technology. In this scenario, the state has an important role in dealing with licensing. This study focused on these aspects in Bhubaneswar, which he divided into centre and periphery. He listed all available facilities at the primary, secondary and tertiary levels. The structure and behaviour of the pharmaceutical industry and its interface with providers and the medical representatives as mediators between the producers, service providers and consumers was discussed. The study showed that fierce competition between pharmaceutical companies led to use of aggressive marketing strategies that was implemented by

medical representatives. The key role of the chemists, how they do not have trained pharmacists and how they act as informal agents for the pharmaceutical industry was delineated. Here, the pharmaceutical companies have deeply entrenched themselves by exploiting the weaknesses of the private sector While the state has a key role in certification, regulation etc., it was found to be very porous and ineffective, particularly in dealing with the pharmaceutical sector. Dr. Seeberg's suggestions for reform included promotion of transparency in government licensing and control activities, establish control mechanisms for drug promotion in collaboration with the pharmaceutical industry, to establish free primary health care services in urban and peri-urban areas, and to ensure that migrant populations have access to such services.

Rama Baru took as point of departure for her presentation the widespread use of private practitioners for outpatient services and linked that to issues of location and distribution mediated by the socioeconomic characteristics of the population served. The growth of the private sector at secondary and tertiary health care levels is largely an urban phenomenon, and there is a clear class gradient in terms of utilization of public and private hospitals. Pointing to the existence of so-called Registered Medical Practitioners (RMPs), many of whom may have little formal education and training in biomedicine, Dr. Baru said that little had been done to integrate them and upgrade their qualifications. On the contrary, the Indian Medical Association had classified them as quacks and campaigned against them. She pointed to a study showing that most had completed high school and that most had an apprentice relation with qualified medical practitioners, to whom they also refer patients. They tend to use the same equipment as QMP, and they provide the same symptomatic 'cocktail' treatment that many QMPs give in order to ensure patient satisfaction. Dr. Baru went on to discuss the heterogeneity of the private sector at secondary and tertiary levels. In terms of reform of the sector she insisted on a systemic perspective that should look at both the formal and the informal sectors that are organically linked. Regulation is important but cannot be implemented by the government alone. There is a need for self-regulation as well. The NRHM provides a window for policy initiatives. She stressed the need to expand this mission beyond poor districts to cover the entire country and to address issues at secondary and tertiary care levels as well, including plugging the private practice of government doctors.

Roy Tjiong presented a brief overview of health service delivery, health programmes and current health status in Indonesia. The MMR and IMR were high and there is a double burden of communicable and noncommunicable diseases. The available data shows that there is inequality in health status across regions and different income quartiles. As compared to other countries in the region, Indonesia fares poorly with respect to IMR, MMR and malnutrition levels. Data on utilization patterns show that the poor do utilize the public facilities. Only around 55% use allopathic services while a large proportion still depend on traditional healers and other informal practitioners. Indonesia has low investments in health; therefore, 88% of health expenditure is out of pocket.

Chorrul Anwar from Indonesia made a presentation on the policy initiatives undertaken to regulate the private sector in Jogjakarta. He enumerated the difficulties in the policy process in order to ensure the provision of good quality care. He identified the pluralism of the health sector as involving a problem of ensuring quality of care. Rules and regulations are not strictly enforced and are often violated. Some doctors practice without license or with other doctor's license. They may dispense medicines and act as drug distributor. Some nurses practice without license and dispense drugs. Some traditional healers provide medical treatment. Some of these irregularities are in accordance with patient demands, since people prefer providers who dispense rather than prescribe drugs. There is a need to strengthen regulation through licensing, certification and accreditation, including all types of systems. In addition there is a considerable amount of cross-practice that makes regulation difficult. He described in great detail the steps, process and stakeholders in the regulation of private providers. Apart from these, he also provided insight into the institutional mechanisms and bodies that have been created to set standards for the regulatory process and to ensure monitoring and surveillance. An interesting feature of this model is that it has space for the 'voice' of consumers through the creation of a grievance/complaint redressal centre in the Mayor's office where complaints can be lodged against private providers/hospitals. He presented some data on the status of regulation and also pointed to the limitations due to the long process and lack of adequate human resources to carry out all the necessary activities. A multi-stakeholders approach involving different levels of government, professional bodies and users of health services has been used in this process of regulation in Jogjakarta city.

Aumnoay Pirunsarn presented some insights from the ongoing study on characteristics and behaviour of private providers in Phitsanulok. He showed the fairly strong presence of the private sector at all levels of care. He pointed to how patterns of health seeking behaviour are mediated by symptoms; period of illness, time spent waiting for practitioner and loss of income. His study showed that the drug store or chemist is the most important player in treatment at the primary level. The attributes of a good drug store were enumerated to include the knowledge of chemists; his ability to give advice and also to follow up patients. The cases of general practitioners showed that they were experienced and had fairly high patient loads.

There was a lively discussion following the presentations. Regulation and the varying patterns across countries were discussed. This is an area for comparative studies across countries in terms of processes, networks used and outcomes – both in terms of successes and failures. Apart from the state there was discussion regarding what NGOs can do to control and regulate pharmaceuticals. There was a recognition that both pharmaceutical and medical providers in the market push their interests aggressively and where these interests are well entrenched, it is harder to put in regulatory mechanisms. There was considerable discussion around the quality of private and public sectors and many of the speakers pointed out that evidence does not support the popular perception that the former provides better quality than the latter. It was felt that in countries (like Thailand) that have higher investments in health, the state is in a stronger position to regulate and define a clearer role for the private sector as compared to countries where the state is either weak or practically non-existent in the financing and delivery of health services.

Health Seeking Behaviour (Parallel Session B)

Chair: C.A.K. Yesudian

Rapporteur: Nupur Barua

Five studies from three countries, India, Indonesia and Thailand, and one drawing from six research projects in the south and southeast Asian region were presented in this session.

The main issues that emerged during C.A.K. Yesudian's presentation on health seeking behaviour among the poor in urban India was the fact that the urban poor is a heterogeneous entity, and that there are significant variations on the basis of income levels and the kind of occupation they are engaged in. As a departure from evidence provided in previous studies, he pointed out that health seeking behaviour is no longer driven by cultural perceptions of illness. He demonstrated, through two studies in Mumbai and Bhopal in India, that pragmatic issues regarding access to, and location of, facilities, as well as the perceived quality of services influenced the ways in which health care facilities are used.

Nupur Barua's presentation examined the reasons for the overwhelming preference of the urban poor for the individual untrained private practitioner in a slum in Delhi. Expenditure on use of government facilities was found to be more expensive than these practitioners. The modalities of treatment inside these clinics and competence constructions of different practitioners by the care seekers were discussed in a context where the patient struggles to survive and the practitioner thrives by providing health services in situations in which they are most needed.

Siwi Padmawati discussed the use of multiple health resources among the poor in urban areas in Yogyakarta, Indonesia and the decrease in the use of public facilities. The increased use of self treatment was emphasized and possible reasons for this development were discussed. The concept of 'cocok' or 'suitable' treatment, amongst the people suggests that the need to formulate and implement public health reform needs to take local perceptions of quality of care into account.

Mubasysyir Hasanbasri's presentation explored the reasons why health card holders in Indonesia use the private sector for treatment and questioned whether the treatment offered by the private practitioners ensured health protection for the public. He suggested ways in which the public sector could be made more accessible and private providers more effective to ensure better health care to the poor.

Angkhanaporn Sornngai presented the health problems among the re-settled elderly 'boat-people' in Phitsanulok, Thailand and explored the economic problems that they faced because of this relocation.

In a discussion of the treatment seeking behaviour of this group, she suggested that a pro-elderly health policy be framed with a holistic focus and with the collaboration of a multi-disciplinary health team.

Finally, Mark Nichter drew upon six of his studies across South and Southeast Asia to present the increasing numbers and use of private practitioners and chemists in several rural areas and towns across the region. The use of primary health centres for the chronically ill, utilization of private services for TB treatment, self medication, and antibiotic use for sexually transmitted diseases were discussed. He drew attention to the need to carefully scrutinize the definition of self–treatment in the context of specific circumstances in which they are used, whether it signifies home remedies alone or whether it is a continuum of earlier prescriptions from a health practitioner or self-prescription of over-the-counter drugs. He emphasized that although providing good quality care is important, changing the perceptions of the people - consumer education - is important and that both the demand and supply of health services are equally crucial in the context of health service reform.

The discussion following the presentations focused on ways in which research could be used to impact policy and how networks of researchers are important in order to raise visibility and translate research into action.

Financing and health expenditures

Chair: Supasit Pannarunothai
Rapporteur: Rama Baru

Dr Agus Suryanto presented the Indonesian health care system and focused on the substantial variation in Indonesia both in terms of demographics and in health system coverage in terms of manpower and infrastructure for both government and private facilities. He pointed to the common dual (government and private) practice among doctors and other health staff in Indonesia. He showed that the current system does not eliminate inequity, measured in terms of health indicators such as under 5 mortality rate and infant mortality rate, which are four times higher for the poorest quintile compared to the richest. He pointed out that 46% of the population in Yogyakarta had no health insurance and that out-

of-pocket spending remained high. He said that the challenges for the health system were underfunding, limited health insurance coverage, social and geographic inequalities and fragmentation, and that there was weak stewardship of the entire system. He then outlined different scenarios with different roles of the state and different mechanisms for financing the health system (insurance-based versus social security). He recommended that the government strengthen its capacity to provide stewardship, preventive care, social health insurance, and free or cheap services to poor and vulnerable population groups. He ended by providing a set of more specific recommendations and stressed the need for new financing mechanisms and provided the case of a quasi-government company that gives health insurance to the poor in Yogyakarta province. Finally, he introduced the Health Care Quality Council that is a recent body in charge of accreditation of medical institutions, among other quality-related tasks.

Prof Supasit Pannarunothai completed the session by presenting comparative findings of the household survey conducted under the project 'Health System Reform and Ethics: Private Practitioners in Poor Neighbourhoods in India, Indonesia and Thailand.' The study was to compare health care seeking behaviour and health care spending within poor households in the three countries. Households were interviewed four times over a period of 12 months. The median income per capita of households in Thailand was substantially higher and household size substantially smaller than in the other three countries. Distinguishing between the poor and the very poor in each site, he noted that these two groups were not very different in terms of income in the Bhubaneswar site, whereas there was more substantial income variation in the other sites. The Poor in Delhi spent 4 times more money on alcohol than the very poor. While there was a big difference in the proportion of the population that reported illness across the four sites, there was not much difference between the two income groups within each site, except for Thailand, where there were fluctuations that could be explained with the small number of participants following depletion due to migration out of the area in the second to fourth rounds of data collection. Health seeking patterns were also very different across the four sites. Interestingly, the Delhi and Bhubaneswar sites showed markedly different patterns, where the former relying much more on private clinics and the latter much more on government services. This was reflected in patterns of spending per visit, which was markedly higher in Delhi that showed a pattern similar to the sites in Indonesia and Thailand – in spite of universal coverage having been implemented in Thailand at the

time of data collection. The study was summarized through a number of observations: The very poor had bigger household size, and income difference was highest in Thailand. The poor and the very poor had similar morbidity patterns, but they fluctuated over the four waves of interviews. They used both private and public services, but the very poor spent less per visit than the poor. They faced similar incidence of payment difficulties, even in Thailand where the universal coverage policy is in place. This difficulty decreased over the period of study. Professor Supasit concluded that private health facilities are important for poor and very poor in urban neighbourhoods and that they should be monitored for quality. The study raised a question as to whether care to the very poor is rationed. This should be further explored. Access to care under the universal coverage policy may be revised to provide better access to the poor in Thailand.

Regulation – scope and limitations?

Chair: Laksono Trisnantoro

Rapporteur: Kira Fortune Jensen and Jens Seeberg

Dr Ashok Kumar stated that Government of India (GOI) is keen to promote various Indian systems of medicine including ayurveda, unani, siddha and homeopathy. GOI has a separate department called AYUSH for this purpose. He said that only 59% of providers are allopathic practitioners. He detailed the system of registration of medical practitioners based on the Indian medical council act of 1956. Medical Council of India (MCI) acts as a statutory body. MCI takes care of medical institutions, defines criteria and rules for medical colleges and recognizes medical schools. MCI also determines the conduct of medical practitioners. If any medical practitioner is found to have carried out malpractice by MCI, he/she is liable to one year imprisonment. MCI has state branches throughout India. Delhi Medical Council was created by an act of the parliament in 1997 and formally established in 2001. The Delhi state council preparers the code of ethics for practitioners in the state of Delhi, receives public complaints against medical practitioners, administers punishment and provides protection to medical practitioners against harassment; it is responsible for ensuring that no un-qualified person practices modern medicine. The concept of 'quack', said Dr. Kumar, refers to a person who does not have

knowledge of a particular system of medicine but yet practices that system of medicine. The directorate of health services and the state medical council is responsible for monitoring practice of modern medicine by un-qualified practitioner. However there are many issues and problems in administration of this system. For example, agencies act only on complaints and do not carry out regular surveillance of their own. 163 complaints had been received by Delhi Medical Council but only 22 had been prosecuted. According to an estimate by Indian Medical Association, about 30,000 non-qualified practitioners are offering medical services in Delhi. Factors contributing to quackery include large demand and inadequate health infrastructure; lack of coordination; poor monitoring and vigilance mechanisms; poor enforcement of the law, long and tedious procedures; lack of awareness among people; and self medication. Quackery can be decreased through improving health infrastructure; improving public health outreach systems; on the basis of the Right to Information Act; based on the National Rural Health Mission that aims to provide health care to all areas of the country; and by strengthening health human resources with Public-Private partnership and capacity building.

Professor Soenarto Sastrowijoto stated that Indonesia has a 'free market' system of medical care. He presented a desk study that intended to identify possible regulatory mechanisms for medical practice; to examine existing rules and regulations; and to analyse ethical considerations with special reference to the poor. He outlined the system of regulatory mechanisms in Indonesia and presented ethical cases reported to the Medical Ethics Honorary Committee, including on advertising, mismanagement, and sexual harassment etc. Cases from newspapers were categorised, including wrong or failed medical interventions, illegal abortion and misdiagnosis. Only three cases had reached court. Professor Soenarto discussed the details of these three cases and related them to the existing regulations as well as to contextual factors such as shortage of health providers and the current financing mechanisms. He pointed out that while the government health care system serves the poor, the government doctors engage in private practice in the evenings and cater to the rich. He said that health sector reforms in education, services, financing is required, that new acts and regulation are needed and that a model should be developed urgently to address the issue of privilege regulation in transition for provincial and district levels.

Professor Supasit Pannarunothai then presented the parallel study in Thailand. He pointed to the issue of information asymmetry between health providers and service users and showed a dramatic increase in complaints made to the Medical Council of Thailand following the economic crisis in 1997 and the introduction of the universal coverage scheme in 2000. He reviewed the decisions made by the Council across various types of complaints and suggested that bias could influence decision-making for some of these. He proceeded to analyse claims made to the Medical Licensing Department and found that a substantial number of cases were sent to court. However, in Phitsanulok, only very few court cases were identified. These were presented. Prof. Supasit also illustrated media coverage through a number of cases. He pointed to recent developments, such as community-based organisations, the setting up of an accreditation system that increases emphasis on patient safety issues, and the introduction of a no-fault compensation system. He also pointed out, that this no-fault compensation system so far has been seriously underutilised and that it may be necessary to educate the judges involved in case evaluation to achieve a desired change in assessing claims.

Dr Jenifer Lobo pointed to the existence in India of rampant malpractice at all levels of the health system. She highlighted the lack of implementation and enforcement and asked whether this is due to corruption or factors in the system that tend to enable malpractice. She raised the issue of government doctors indulging in private practice as a main issue in that context and said that the uncovered health needs of the large population also allowed private practitioners to practice without control and quality measures being in place or being enforced. In the context of private hospitals she mentioned pressure from patients and relatives, the mechanisms being put into place to protect health providers against the consumer protection act, and the influence of private insurance companies who want to dictate treatment on the basis of economical rather than medical grounds. She asked whether we can find other solutions to these problems than regulation, which had not been particularly successful in the past.

DAY 2 (21 June 2007)

The proceedings of Day 1 of the workshop were summarized by Jens Seeberg. He pointed to four cross-cutting themes, i.e. Health care seeking and patient rights; Rights, regulation and legislation; Private health care delivery and quality of care; and Health financing. He pointed out some of the

important issues under each heading and said that the group work planned for the day would allow for further discussions of these four themes.

Professional organisations and other NGOs

Chair: Jenifer Lobo

Rapporteurs: Siddarth Agarwal and Jens Seeberg

Dr Siddharth Agarwal in his presentation pointed out that in 2007, for the first time in the history of mankind, the urban population would become larger than the rural. He mentioned the rapid growth of urban slums and said that health care provision to this population was one of the growing challenges for governments and civil society. He proceeded to show that in terms of basic health indicators, there is vast disparity between urban average and urban poor populations, and that the urban poor are often worse off than rural populations in spite of geographic proximity to health care services. He said that public-private mix was required to address the needs or the urban poor and went on to offer a number of different types of partnerships, involving NGOs (private non-profit), mobile clinics and, to a lesser degree and perhaps with more difficulties involved, individual private (for profit) practitioners. Finally he highlighted the need to map the needy urban populations, since, very often, official registration only covers a fraction of the actual slum dwellings. He pointed to the fact that temporary and migrant populations often are denied access to health care services and that partnerships need to be forged to address their needs.

Ms. Widyawati Muhasan then introduced the private health sector seen from a nursing perspective. She described the nursing situation in terms of the number of providers in the province of Yogyakarta and pointed to issues of education, professional organization and legislation. Based on a qualitative study, she found that nurses play a role in private health care and sometimes run their own private clinics where they provide medical treatment, and she pointed to the related licensing problems. However, patients felt they had easier access to these clinics than those run by medical doctors, and that they received quicker and more affordable treatment. She pointed to issues of delegation of medical practice by medical doctors to nurses and said there was a lack of supervision, monitoring and evaluation.

Mr. Marius Widjajarta discussed various pro-poor programmes that had been implemented in Indonesia since the financial crisis in 1997. He went through the implementation process in detail and pointed to various problems in terms of unclear distribution of responsibilities, insufficient transparency and weak monitoring. He also mentioned that insurance cards were sold at the market and that often, they were used by other people than the poor whom they were supposed to benefit. He provided a number of examples of specific problems, such as costs not having been refunded, illegal administration of the system, etc. He concluded by hoping that the current system would improve under tight community-based monitoring.

After a short break, Dr. Somsak Lolekha talked about the "Role of Thai Medical Council in Regulating Ethics of Private Practitioners". He outlined the history, objectives and organization of the Council and its links with educational institutions. He then presented the various activities of the council and presented data concerning ethical claims made during 1973-2005. There had been a steep increase in the number of claims around 1999. He mentioned the various types of sanctions that the council could use when dealing with the claims. These included Dismissing the accusation; Warning; Reprimand; Suspension of the license for a period 1-24 months; and Revocation of the license. He outlined various strategies the doctor could use to prevent litigation, include good communication skills and maintaining a good relationship with the patient. He concluded by introducing a tort reform, that would imply the following elements: No criminal charge against doctors who have good intention to treat patients; Cap damages; Encourage early offers for settlement; Use medical courts; Compensate claims through a no-false administrative system; Implement pre-designated compensable events; and Shift liability from individuals to organizations.

Jon Ungpakorn, in his presentation, focused on the role of civil society to push the medical establishment and the government for reform. He emphasized the role of civil society and community-based organizations and used the flourishing of activism around HIV/AIDS as a case in point. He mentioned how civil society had played a constructive role in the formulation of the universal coverage policy. He stressed that this could not only be based on a concept of health for the poor but had to be

based on a principle of health for all which would also include the poor. Mr Jon stressed the need to include members of communities in medical institutions, from hospital boards to the medical council. Using the case of AIDS, he said that access to antiretroviral treatment had been included under this policy as a result of community-based pressure. He said that while many different groups had joined hands to form a strong community around AIDS, this had paved the way for other groups and networks to follow and pursue issues related to other diseases. He drew attention to the a range of issues where civil society had a crucial role to play in Thailand, such as community health education and care services; policy advocacy concerning access to prevention, care and treatment; support for malpractice and negative outcome compensation; access to essential drugs; and community health funds. He also called attention to the global drainage on the health system, where middle class patients from western countries go to countries such as India and Thailand for treatment, because it is cheaper than being treated in their own country. Such global movements drain the Thai government system for resources.

Anil Jacob Purty set out to define partnership and mentioned issues of capacity of the private partner, advocacy, accreditation and regulation by the Government as being important for the success of such partnerships. Using experiences from the Pondicherry Institute of Medical Sciences, he highlighted activities such as teaching and training, primary health care, community-based research, health education and school health programmes, liaison with Government departments for National Health Programmes (such as immunization programmes and tuberculosis control), and co-ordination with national and international NGOs for public health practice. Dr. Purty then provided morbidity data to illustrate the success of the approach adopted. He concluded his presentation by mentioning some of the challenges for public-private partnerships, such as cost containment, effective use of private resources, logical diversion of public resources, synergy to reduce duplication and resource mobilization.

Group Work 1: Comparative Perspectives

Jens Seeberg introduced a format for the afternoon's group work. Four groups were established and asked to work with one theme each. All three countries (India, Indonesia and Thailand) would be represented in each group. The groups would address three questions under their respective themes.

both for each country individually and in a comparative perspective. The outcome of the group work was to provide input for the planned country-specific group work that would take place on Day 3. The group work formats with the result from each group have been inserted as Annex 3 of this report.

DAY 3 (22 June 2007)

The meeting had invited Mark Nichter to share his observations. Prof. Nichter called attention to the dual chronic state of ill-health and poverty that sets the agenda for coping and survival strategies for the urban poor. He pointed to questions such as 'why would both sides bother to work together in a public-private partnership?' What could be motivating factors – or convertible forms of capital – besides money? He called attention to the notion of health citizenship as part of the wider concept of biosociality, i.e. mobilizing people in networks around diseases such as HIV/AIDS and diabetes. He mentioned the need to gradually and incrementally enhance the credibility of the health care system. He then shifted focus and said that there was a need to take the aging of populations and the increase of chronic disease much more into account in policy discussions. He called for policy makers to speak up and raise issues for research and tell researchers in which form they can use research. He suggested using stakeholder analysis as a way of translating results into policy. He then mentioned a number of research issues that he felt needed more attention, including research on the role of the pharmaceutical industry; applied research on use of modern technologies to give practitioners swift access to appropriate information and CME; and analysis of the impact of rhetoric and language in general on the way we understand these problems. He posed the challenge to the meeting to move beyond cases and address the issue of 'so what' – where to go after the meeting?

Government perspectives

Chair: Prof. Soenarto

Rapporteur: Jens Seeberg

Dr. Deoki Nandan started his presentation by stating the dominant role of the private health care sector in India and compared it with the government sector in terms of quality, access and costs for the

payment, mentioning that existence of corruption in the government sector often required patients to pay bribes to doctors to receive appropriate treatment. He said that Indian Medical Association systematically had resisted regulations and that Medical Council of India had taken very little action against doctors violating the code of ethics. He noted the change in the private health sector from individual clinics and small nursing homes to private hospitals and hospital chains. He noted that the quality of private clinics and nursing homes varied dramatically. Key issues with unsatisfactory quality included disposal of medical waste, lack of labour rooms, dirty beds, poor lighting, unsatisfactory recording procedures, and not displaying license prominently. He said that the sector is poorly regulated and that quality assurance mechanisms are not in place, but that regulation has been passed recently in some areas, including for drugs, medical practice and health facilities. He said that it was necessary to impose greater social accountability on private providers, to make a certain proportion of private services available to the poor, to reconsider geographical distribution of health services, and to explore the potential of franchising. He then introduced elements of the National Rural Health Mission (NRHM) in terms of community involvement, financing, monitoring of standards of care, improved capacity for management, and innovation in human resource management. Recognizing the dominant role of the private sector, he said that there was a need to reform regulation and make processes transparent and people involved accountable. Dr. Nandan outlined the existing scenario for public-private-people-partnerships under the NRHM that included guidelines for PPP in national health programmes, social franchising, contractual appointments, contracting services such as diet and catering, laundry, security and IEC programmes. He said that Government of India has constituted a Technical Advisory Group, consisting of government officials, development partners and other stakeholders to conceptualize strategies under this heading. An Urban Health Task Force has been established as an offshoot of the NRHM, which recommended collaboration with NGOs, situational analysis and mapping of slums, improved management of urban health centres, use of outreach clinics in urban slums, and emphasis on community-based organizations.

At the workshop, it was announced that the Government of India was about to launch its Urban Health Mission. Dr. Siddharth Agarwal provided information on this topic, as follows:

India has been urbanizing rapidly in recent decades. The urban population of India grew by 68 million during the decade 1991-2001 which translates to a decadal growth rate of 31.2 per cent. This is nearly double the rural population growth rate. Along with urban growth there is a rapid urbanization of poverty. 100 million persons or one-third of the urban population of India resides in slum or slum like conditions. The urban poor are the fastest growing sections of the population and the UN-HABITAT estimates that the urban poor will reach 200 million by 2020.

The urban slum communities suffer from poor health outcomes, which do not get reflected in the commonly available data sources that show rural-urban comparisons. Disaggregating health indicators within urban areas by Standard of Living Index (SLI) reveals some startling findings. Among urban poor households child mortality rate (U5MR) (101.3) is nearly thrice, severe under nutrition is twice (23%) and complete immunization is almost half (43%) than corresponding figures among urban high income groups. Likewise the reach and utilization of essential preventive health services is overwhelmingly low with 4% using birth spacing method and only 3 out of every 10 children affected with diarrhoea receiving ORS.

The Government of India has recognized the growing urban poverty and their poor health. Urban health received special mention in National Population Policy 2000, National Health Policy 2002, 10th Five Year Plan, and the second phase of the Reproductive and Child Health Program (RCH II) and the very recent National Rural Health Mission (NRHM) (2005-2012).

In June 2005, the Government of India constituted a Task Force to advise the NRHM on strategies for urban health care. After a series of deliberations between August and October 2006, the Task Force has recommended that there should be a National Urban Health Mission on the model of NRHM. In terms of urban health care strategies, the Task Force recommends a) an Urban Health Centre (UHCs) catering to every 50,000 population (which is anticipated to include about 25,000 urban poor); b) a Second Tier Health Facility for 250,000 population covering 5 UHCs and forming a 'Health Zone'; c) regular outreach services in the slums by ANMs to ensure the provision of preventive, promotive and curative services; d) community level activities primarily by slum based Link Volunteers (LVs) and Women's groups with coordination support from NGOs; e) an enhanced role of urban local bodies, private sector,

NGOs; and f) improved coordination of the health department with other relevant departments including Ministry of Urban Housing and Poverty Alleviation, ICDS in improving the health of urban slum communities. The package of services recommended for First Tier Level and through outreach services includes ANC, PNC, child health services, family planning services, treatment of communicable diseases, counselling, and laboratory services. At the second tier maternity services, neonatal, paediatric services, reproductive health and other general hospital services have been recommended. The Government accepting the recommendations of this Task Force, in June 2007 announced the decision to soon launch the National Urban Health Mission.

Dr Agus Purwadianto, on behalf of the Government of Indonesia, in his presentation gave an introduction to the Indonesian health care system in terms of organization and structure. He said that current priorities for the system included maternal and child health; poor people health services: empowering health personnel; communicable diseases and malnutrition, health crises due to disasters; and health services for remote areas and islands. Using key health indicators, he highlighted some of the achievements in the past. Dr Agus then shifted attention to the legal framework and discussed the complaints to the Medical Ethics Honorary Board in terms of type of complainant, medical specialty involved and type of complaint. He continued by looking at cases reported to the police and related these to the issuance of the Medical Practice Act. He raised the issue of professionalism and said that there was a public perception that medicine failed to regulate itself in a way that can guarantee competence, and that it put its own interest above that of patients and the public. Also, he said that in the past, the medical fraternity protected incompetent and unethical colleagues in the name of collegiality. He introduced a series of steps that were taken since 2003 to address this issue, including reform of the bodies that were responsible for addressing these problems on a daily basis. Dr Agus highlighted the concept of professionalism as a key to address such problems and said that professionalism had to be based on a principle of primacy of patient welfare; a principle of patient autonomy; and a principle of social justice. He related this discussion to the ethico-legal framework in Indonesia and to the role of bureaucracy as a formative force in the system, which could work both in positive and negative directions. He said that transparent administration and management were keys to improving the system and used the dispensing and sale of drugs as a case in point. He concluded that in Indonesian health regulation, the concept of professionalism was being considered. Health reform

policy to support the poor and least advantaged people could be a panacea for their dissatisfaction of "out of pocket" health care system while going to a managed care system using the social security act and health insurance regulation, beginning with the Minimum Service Standard.

Group Work 2: Country-specific Perspectives

Chair: Yati Soenarto

The purpose of the final group work was to develop key recommendations for policy makers for each country on the basis of a) the research input that had been fed into the workshop, and b) the group work about comparative perspectives that had been completed on the previous day. Three groups were formed, one for each country, and the assignment, that was presented by Jens Seeberg, was to address all four themes that had been discussed by individual groups on the previous day. The results are provided in the formats below.

INDIA

THEME 1: Health Care Seeking and Patient Rights

Prioritize the three main problems/needs related to health care seeking and patient rights.

1. Access barriers in terms of a) physical, social access and quality of public health facilities; and b) affordability of the public sector.
2. Inadequate health infrastructure and manpower vis-à-vis established norms
3. The poor often use private sector providers with questionable qualifications; or are forced to visit expensive private providers
4. High proportion of out-of-pocket expenditures for health and lack of health insurance for the poor

Primary recommendation for policy

- Policies should focus on demand, strengthen supplies and quality of services and establish linkages between available public and private health providers.
    - Motivation, sensitization, capacity building (about social skills) and recognition of better performers should be pursued
    - Regular outreach services for vulnerable slum clusters should be ensured
    - Linkages with available health providers through slum based *'link volunteers'* should be developed; community-based health groups should be engaged to enhance utilization of health posts
    - Education of urban poor communities should be strengthened. This should include knowledge about a) healthy behaviour; b) appropriate services; c) rights to health care

Secondary recommendations

1. Capacity of informal sector should be built and practitioners linked to the public health system and/or organized
2. Partnerships with socially responsible private providers should be developed

THEME 2: Rights, Regulation and Legislation

Prioritize the three main problems/needs related to rights, regulation and legislation in terms of impact.

1. Poor understanding among urban poor of their rights vis-à-vis the public sector and provisions available to them; weak negotiating power
2. Migration, domicile challenges and social exclusion that impair the ability to access rights/health services/entitlements
3. Weak regulation for the informal private health sector
4. No separate legislation/regulation for private sector

Primary recommendation for policy

- There is a need to design and implement an urban health care service delivery system, keeping in mind city-specific situations

Secondary recommendations

1. To map all ***listed*** as well as ***unlisted*** urban poor clusters including pavement dwellers, brick, lime-kiln workers, construction workers on city map for urban health planning, implementation and ensuring right to health services
2. To enhance negotiating capacity of urban poor communities to improve ability to avail entitlements
3. To develop regulation of private informal sector to ensure that they play a meaningful role
4. To develop regulations for need-responsive public-private mix and modify them based on initial experience

THEME 3: Private health care delivery and quality of care

Prioritize the three main problems/needs related to private health care delivery and quality of care.
1. Lack of standards of quality and fee structure in a context of demand, utilisation and growth of less qualified practitioners
2. Lack of continued upgrading of knowledge and skills of all private providers
3. Inadequate linkages between private and public health sectors
Primary recommendation for policy
• Legislation to ensure optimal standards of private providers in the informal as well as the formal sector should be framed and energetically implemented.
Secondary recommendations
1. To establish a system of periodic CME for both formally qualified practitioners and informal private practitioners, involving available agencies and professional bodies
2. To promote and ensure quality of care

THEME 4: Health Financing

Prioritize the three main problems/needs related to health financing
1. High out-of-pocket expenditure owing to high cost of health care
2. Low investment and poor distribution of financing for human resources and infrastructure
3. Imbalance of financing on preventive and Primary care/OPD vs curative/hospital care
4. Lack of health insurance systems for the poor

Primary recommendation for policy • Increase rational (i.e balanced with respect to preventive, primary and hospital care) investment in public health services with a focus on the urban poor
Secondary recommendations 1. Establish health insurance for the poor, based on learning from small-scale community health financing initiatives in different states

INDONESIA

THEME 1: Health Care Seeking and Patient Rights

Prioritize the three main problems/needs related to health care seeking and patient rights. 1. Self-medication (70%) and harmful medication 2. Patients' demand leading to irrational medical treatment 3. Imbalance in accessibility, affordability, and distribution of health services
Primary recommendation for policy • Strengthen proper information and education (both for patients/consumers and providers) o Socialization concerning and enforcement of regulations on patients' and consumers' right o IEC through CBOs
Secondary recommendations • Conduct research related to financial and cultural barriers to formal health care system

THEME 2: Health care seeking and patient rights in terms of impact

Prioritize the three main problems/needs related to health care seeking and patient rights in terms of impact 1. Growing market of traditional and lay medication (health resources) 2. Black Market 3. Increasing burden of illness due to untreated and chronic diseases
Primary recommendation for policy • Enforcement of related regulations • Quality improvement of public primary health care, thereby increasing the credibility of the public health system
Secondary recommendations 1. Involving district health office in monitoring and controlling 2. Ethics and legal awareness of various parties (universities, MoH, professional organizations)

THEME 3: Private health care delivery and quality of care

Prioritize the three main problems/needs related to private health care delivery and quality of care 1. Private providers are marginalized or neglected by the public health agencies 2. Over/irrational medication 3. Cost variation
Primary recommendation for policy

- Optimizing the use of private health care in accessing the poor
- Integrating private providers to act as agents for public health
- Purchase of private health service for the poor by the government (outsourcing the service for the poor through private sectors)

Secondary recommendations

- Purchase of private health service for the poor by the government (outsourcing the service for the poor through private sectors)

THEME 4: Health Financing

Prioritize the three main problems/needs related to health financing.

- Although there had been an increase of public finance in health, in fact private finance still dominates the health sector
- The main problem: insufficient government budget and low willingness to improve the quality of public health care.

Impact

- Low credibility of primary health care service (out-patient)
- No equitable distribution of in-patient care resources
- In terms of in-patient care, the urban poor are better off than rural and remote poor. For out patient care they have an alternative to public service in the "unregulated" private sector
- For rural poor and remote areas: In-patient is not as good as urban poor (geographical in-equity). Less hospitals and medical doctors.

Primary recommendation for policy Tapping more resources for health • Increasing public budget: central, provincial and district governments • Expanding private finance through insurance scheme, not fee-for-service
Secondary recommendations • Improving the quality of primary care (requires more research) • Reducing the gap of geographic inequity: "more suitable medical doctor/specialist education for remote areas" and push medical doctors to work in remote area (operational research) • Developing medical care network in outer provinces

THAILAND

THEME 1: Health Care Seeking and Patient Rights

Prioritize the three main problems/needs related to health care seeking and patient rights. **Consumer:** • Accessibility problems in terms of physical and social environments, affordability problem related to travel expenses, etc. • Lack of knowledge of rights for service. • Unrealistic expectation; false need; low trust on services provided under the universal coverage scheme. **Provider:**

- Health care service not suitable in terms of consumer needs (convenient timings, etc.)
- No strict regulation of access to services.

Primary recommendation for policy

Empowerment of both consumer and provider.

Consumer:

- Provide knowledge about the rights to service and regulation.
- Encourage community participation in health care system.

Provider:

- Develop leadership skills among health providers.

Secondary recommendations

Further research is recommended to answer these research questions:

- How to understand the lifestyle of the urban poor and how to improve the quality of care to fit their needs?
- How to raise the trustworthiness on the public system from the patient and provider perspectives?

THEME 2: Health care seeking and patient rights in terms of impact

Prioritize the three main problems/needs related to health care seeking and patient rights in terms of impact.

1. Most of health workers in private sector are not MDs, whereas in public sector there are more MDs.
2. There are limitations in the ability to reduce inequity problems; gender equity.
3. The law to control health premises is available, but it addresses only the private sector.

Primary recommendation for policy Enhancing health personnel to provide a holistic health service; as well as increasing the standards of hospitals according to Hospital Accreditation or ISO 9000.
Secondary recommendations • Explore the weaknesses and strengths of the private health systems. • Research and development on implementation and evaluation of health service quality.

THEME 3: Private health care delivery and quality of care

Prioritize the three main problems/needs related to private health care delivery and quality of care. 1. Inaccessibility of the private health sector for the poor. 2. Lack of monitoring and evaluation system on private health sector. 3. Over-treatment and expensive treatment.
Primary recommendation for policy • Core package of universal coverage scheme should be designed to cover private health care and extended to community health. • Strengthening the monitoring and evaluation of private health sector using internal and external assessors with coordination of multiple agencies and based on clearly defined quality standards. • Payment to hospital on DRG basis should be integrated into private hospitals.

Secondary recommendations

- Feasibility study of UC core package for private health care.
- Study on effectiveness of private health care providers.
- Study on cost-effectiveness of private health care delivery and quality of health care.

THEME 4: Health Financing

Prioritize the three main problems/needs related to health financing.

1. Inequities in health service delivery between income groups (intra-urban and rural-urban differentials).
2. Risk for catastrophic illness (and out-of-pocket payment) especially in private sector.
3. Lack of resources for preventive care.

Primary recommendation for policy

- Inequity of health service delivery between income groups (intra-urban, rural-urban) should be reduced.
- There should be adequate source of financing for provision of preventive care by both public and private sectors.
- Source of fund for the compensation of adverse events in private sector should be studied.

Secondary recommendations

- The purchasing role to enhance equity and a strategy to increase sources of financing should be explored.
- Methods for controlling quality of health care (i.e. regulations, monitoring systems etc.) in relation to financing methods should be arranged.
- Methods for encouraging preventive care through payment systems should be studied.

CLOSING SESSION

Chair: Prof. Supasit Pannarunothai.
Rapporteur: Nupur Barua

The concluding session brought to the table final comments from participants from all the countries. Jens Seeberg began the session by outlining the main themes that had emerged during the deliberations in the past three days under the following heads: patient rights, self-medication, inequity in access to health services, out-of-pocket expenditure on health and issues around insurance for the poor. The provision of health services was the central issue in all the three countries – India, Indonesia and Thailand.

In the discussions that followed, it was felt that while the workshop offered a very useful forum to discuss the complexities of the problems regarding the urban poor in all the countries, there had not been enough time to discuss the recommendations and lessons learnt from each country in detail. It was suggested therefore that all the recommendations be placed on the project website to enable access by all countries. The possibility of framing advocacy materials for each country was deliberated.

Supasit Pannarunothai from Thailand facilitated a discussion on 'what next?' - at both the network-level and country-level. Soenarto Sastrowijoto from Indonesia announced that they would hold a meeting of representatives from the government, the NGO sector, and the university to discuss and analyze inputs from India and Thailand and to develop a plan of action of reform of various regulations at the district level in Yogyakarta. They would present the same to the government to stimulate action at the regional level. C. S. Pandav from India felt that this workshop had provided an opportunity to bring together people from various levels – from the ministry, the research community, the political arena, and from medical colleges – to discuss and share experiences of the complexities of health provision for the urban poor in all three countries. He informed that an India Group would be formed, along with the National Institute of Family Welfare, to discuss the current research findings and policy implications of the same vis-à-vis the recently announced Urban Health Mission by the Govt. of India.

The group would also draw lessons from the Indonesian and Thai experiences to see 'what works'. Furthermore, he emphasized the need to go beyond the local level in each centre to frame a regional agenda keeping in mind common areas of interest within the overall focus on urban health and hoped that Danida would be associated with subsequent efforts in the region. Prof. Supasit carried the discussion further by emphasizing the need to develop action plans at provincial, country and regional levels and said that it was important to focus on particular examples as a basis for policy development and on ways to do advocacy for a more equitable and rights-based health system.

C.A.K. Yesudian from India emphasized the timeliness of this meeting when the Govt. of India, for the first time, was focusing on urban health as a priority area and that this exercise should feed into the proposed Urban Health Mission. The learning about the less-qualified practitioners could be of particular importance in this context. At the regional level, he asserted that this group could contribute to larger studies on public-private mix and health financing and suggested that more countries from the region, Sri Lanka, Bangladesh and Malaysia, could be added to form an Asian Health Observatory in the lines of the European Health Observatory. This would not only expand the area of study but could also influence policy.

Dr. Deoki Nandan, as a representative head of the National Institute of Health and Family Welfare emphasized that his organization functions as the think tank for the MoHFW in India and offers opportunities for capacity building, research and advocacy on urban health management and health financing. He emphasized that beneficial collaborations across various levels could be forged with his organization to focus on various issues regarding urban health development in the country. Dr. Ashok Kumar from the Govt. of India conveyed that the Director General of Health Services was very pleased that this inter-country effort was taking place. He said that he would carry the experience back and would be interested to facilitate a possible development of a network, so that the technical competence of this group could be used to invigorate a wider movement in the region to eventually translate the research into action.

A representative from the City Health Office in Yogyakarta said that lessons learnt during the workshop could be implemented at the district level and collaborations with the university and between

NGOs and the government could provide research grounding for improving the quality of life in the city, especially with regard to primary health care provision. Laksono Trisnantoro from Indonesia stressed that an international perspective could be gathered through collaborative ventures of this sort and emphasized the importance of holding meetings of this kind. He sought information on post-project avenues for holding subsequent meetings. He particularly drew attention to the need to focus on regulation and financing for the poor.

Jens Seeberg said that he hoped that this meeting would establish the much-needed platform for follow-up stakeholder meetings, involving researchers, NGOs, and civil society organizations. The main problems that needed attention are issues regarding access, wrong medication (over-use or under-use), equity, financial security, and the functioning of the private sector. In addition, he stressed the need to look more closely at the pharmaceutical industry and the impact that the lack of regulation of the industry has on the urban poor residing in slum areas through the private practitioners. Issues concerning private insurance and the way it influences health service delivery in the private sector to the poor need to be examined. He asked what could be done with the research and pointed to the need to go beyond the case studies. The potential influence of WHO in taking the agenda further beyond the local level was emphasized.

Rama Baru pointed out the need to go beyond the policy makers and to take into consideration the people's health movements which play an important role in policy advocacy. She suggested that a summary of the present study be given to such groups and highlighted the importance of publishing the proceedings in reputed journals like the National Medical Journal of India and The Economic and Political Weekly. Media reporting of such a meeting would influence civil society.

Yati Soenarto shared experiences about the decentralized management in the Indonesian initiative in control of diarrhea and emphasized the need to influence the government to translate research results into policy. The Indonesian team highlighted the importance of budget allocations, transparency of public health administration and surveillance of data in public health programmes for the poor and drew attention to problems that accrue from bad regulations.

Further discussion centered on the importance of development of research of this kind in the region and the possibility of further collaborations of this kind. The need for academic publications and collaborations with academic organizations for such research was highlighted.

Finally, Jens Seeberg summarized the main issues that emerged from each country under four cross-cutting themes:

1. **Health care sector and patient rights:** Harmful medication consumption, the need to focus on the real problems, for instance urbanization and migration into cities, the role of health citizenship and the need to rethink health care delivery to people who are on the move;
2. **Rights, regulation and legislations:** Implementation and enforcement, mechanisms for conflict resolution, enforcement of disciplinary measures that have been put into place as one mechanism, strengthening of positive motivations as another important mechanism, and issues regarding how to make profit and still provide good quality services in the private sector;
3. **Quality of services:** Strengthening of government services in urban areas, the need to include the middle class to ensure that service delivery mechanisms go beyond providing poor public health for the poor, incorporation of less- qualified private practitioners, establishment of dialogue in a scenario where the current move of raids in Delhi have proven not to be very effective, and finding news ways to access continued health education;
4. **Health Financing:** The Universal Coverage Scheme held suggestions for India along the same lines, but there were also important lessons to be learnt from the Thailand experience in pursuit of equitable funding mechanisms.

He closed the session by reiterating that this forum, the ongoing research, and inputs from the participants could be used by the group during the proposed national-level workshops in each country. He suggested that policy briefs be prepared by each country for these meetings to facilitate the process of taking research to action. Furthermore, he said that this forum could also facilitate the formation of networks and collaborative groups in the region.

ANNEX 1: Programme

20 JUNE: RESEARCH

08.00-08.30 Registration

08.30-09.30: Inaugural session
Introduction by Supasit Pannarunothai
Welcome address by Mondhon Sanguansermsri, President, Naresuan University
Opening remarks by Jens Seeberg, University of Aarhus
Inaugural Address by Special Guest of Honour Samlee Plianbangchang, Regional Director, WHO (SEARO)

09.30-10.00: Coffee (registration cont.)

10.00-12.00: Health Sector Reform and Public Private Mix? Keynote presentations and panel discussion *(Chair: Prof. Supasit)*

- Chandrakant S. Pandav (India): *Health Sector Reform in India*
- Laksono Trisnantoro (Indonesia): *Health Sector Reform in Indonesia: A scenario planning analysis in controlling private sector*
- Pongpisut Jongudomsuk (Thailand): *Health Sector Reform: the case of Thailand*
- Firdosi Mehta (Indonesia): *Successes, scope and limitations of public-private partnerships in Asia. Experiences from TB control and beyond*
- Reidar Lie (Norway): *Private health care, health and human rights*

12.00-13.00: Lunch

13.00-15.30: Private health sector – Parallel sessions

A. Quality of care and dynamics of the health system *(Chair: Dr. Pongpisut)*

- Jens Seeberg (Denmark): *Market dynamics and private health care delivery. The case of Bhubaneswar, India*
- Rama Baru (India): *Structure and Quality of Private Health Services in India*
- Roy Tjiong (Indonesia): *A Dynamic of (Private) Health Sector and Quality of Care*
- Choirul Anwar (Indonesia): *Health Service Policy for Private Sector in the City of Jogjakarta*
- Aumnoay Pirunsarn (Thailand): *Private Health Provider Behaviour and Clinical Communication Patterns: Cases from Phitsanulok, Thailand*

B. Health Seeking Behaviour *(Chair: Dr. C.A.K. Yesudian)*

- C.A.K Yesudian (India): *Health seeking behaviour of urban poor in India*
- Nupur Barua (India): *The discreet charm of the private practitioner: Access, utilization and quality of health care in a slum in Delhi*

- Siwi Padmawati (Indonesia): *Searching for Suitable Cure: Understanding Medical Pluralism in Urban Poor Neighborhoods in Jogjakarta, Indonesia*
- Mubasysyir Hasanbasri (Indonesia): *The use of private provider among health card holders in Indonesia*
- Angkhanaporn Somngai (Thailand): *Health Problems and Needs among Low-Income Elderly in Phitsanulok, Thailand*
- Mark Nichter (USA): *Lessons from studies of health care seeking in pluralistic health care arenas of South and Southeast Asia*

15.30-16.00: Coffee Break

16.00-16.50: Financing and health expenditures *(Chair: Prof. Supasit)*
- Bondan Suryanto (Indonesia): *Financing Health Sector: Public and Private Mix in Jogjakarta*
- Supasit Pannarunothai (Thailand): *Health seeking and spending of people in four urban poor neighbourhoods in India, Indonesia and Thailand*

16.50-17.00 Break

17.00–18.30: Regulation – scope and limitations? (*Chair: Dr. Tawesak)*
- Ashok Kumar (India): *Regulation of Medical Practitioners in India*
- Soenarto Sastrowijoto (Indonesia): *Regulating Health Professions: The Dilemma in Medical and Health Practices for the Poor in Indonesia*
- Supasit Pannarunothai (Thailand): *Systems of Ensuring Ethics and Quality in the Thai Private Healthcare*
- Jenifer Lobo (India): *Medical Malpractice in India: Is Regulation the Only Solution?*

19.30: Workshop Dinner

21 JUNE: COMPARATIVE PERSPECTIVES

09.00-09.30: Summary of Day 1

09.30-10.40: Professional organisations and other NGOs *(Chair: Dr. Lobo)*
- Widyawati Muhasan (Indonesia): *Independent Private Nursing Practice in Indonesia, is it essential? A Case Study*
- Marius Widjajarta (Indonesia): *Poor Community Health Monitoring In Indonesia Since Monetary Crisis*
- Siddarth Agarwal (India): *Public Private Partnerships for Improving Health of the Urban Poor: Lessons and Best Practices from India*

10.40-11.00 Coffee Break

11.00-12.00 Professional organisations and other NGOs (Cont.)

- Somsak Lolekha (Thailand): *Role of Medical Council in Regulating Ethics of Private Practitioners*
- Jon Ungpakorn (Thailand): *Roles of NGOs for Health of the Poor*
- Anil Jacob Purty (India): *Public-Private Partnership for Health Care. Our experience and the road ahead*

12.00-13.00 Lunch

13.00-15.30 Afternoon: Group Work – Cross-country perspectives (South and Southeast Asia)
(Chairs: Gr.1: C.A.K. Yesudian, Gr.2: Deoki Nandan, Gr. 3: Ashok Kumar, Gr.4: Rama Baru)

15.30-16.00: Coffee Break

16.00-17.00 Plenary presentation of group work results (Dr. C. S. Pandav)

22 JUNE: COUNTRY PERSPECTIVES

09.00-10.20

- Government perspectives (Chair: Prof. Soenarto)
  - Deoki Nandan and Siddharth Agarwal (India): *Private Sector in the context of the National Rural Health Mission and Urban Health Task Force Recommendations*
  - Agus Purwadianto(Indonesia): *New Regulation on Health Services in Indonesia*

10.20-10.40 Coffee Break

10.40-12.30 Group Work – Country-specific Policy Perspectives

12.30-13.30 Lunch

13.30-15.00 Plenary presentation of group work results (Chair: Dr Yati Soenarto)

15.00-15.30 Coffee Break

15.30-17.00 Report with recommendations (Chair: Prof. Laksono)
Closing Session

SATELITE MEETING

22 JUNE

20.00-22.30 Disaster management in the light of the Yogyakarta 2006 earthquake and the 2004 tsunami

- Retna Siwi Padmawati (Indonesia): *The 27May06 Earthquake in Yogyakarta Province*
- Widyawati Muhasan (Indnesia): *Community Empowerment by Mobile Rehabilitation*
- Jain Veeraphing (Thailand): *Mudslide and Community Help in the North of Thailand*
- Vorasith Sornsrivichai (Thailand): *Man-made Disaster: Violence in the Deep South of Thailand*

ANNEX 2: List of participants

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ANNEX 3: Group work on comparative perspectives

Below, the outcome of the first group work on cross-country perspectives is reproduced in a minimally edited form. The outcome was used as basis for the second group work on country-specific recommendations that has been integrated in the main report.

Health Care Seeking and Patient Rights

Chair: Prof. C.A.K. Yesudian. Rapporteur: Nupur Barua. Members of the group: Indonesia: Roy Tjiong, Widyawati Muhasin, Siwi Padmawati. India: CS Pandav, C.A.K. Yesudian, Nupur Barua. Thailand: Dr. Angkhanaporn Sprnngai, Panada Taechasubamorn, Vorasith Somsrivichai. Observer: Mark Nichter (USA).

	INDIA	INDONESIA	THAILAND	Lessons learnt / recommendations/conclusions
What do you see as the three main problems/needs related to health care seeking and patient rights?	1. Access – location and quality of public facilities. Raising levels of credibility of the formal system - 'nothing in the govt. system 'works' 2. Less-than-qualified practitioners providing questionable (dangerous) treatment to fill the gap – issue of patient safety • Networks (?cartels) between various levels of health care providers (Practitioner -	1. Self- medication very high. Delay – TB, ARI 2. Patients demand for health service leads practitioners to give irrational treatment Quick fix – practitioner pressure 3. Patient rights: (Accessibility and affordability of the health services)	1. Lack of knowledge of patient rights for services 2. Unrealistic expectations and dissatisfaction; low quality of care if free 3. Accessibility and Affordability of the Health service	1. How to raise the credibility of the public system. Study from the patient and provider perspective 2. Documenting legislations related to patient rights and safety and their implementation status

	diagnostic centres - nursing homes) ▪ What do we do? (rid, regulate, train) 3. Lack of awareness of patient rights (quality of care) ▪ Out-of-pocket medical exp and complete lack of health insurance			
Please describe recent/current/planned initiatives have been taken to address these issues, if any.	1. National Rural Health Mission ▪ Private Practitioners ▪ Urban Health Task Force ▪ Recent announcement about an Urban Health Mission 2. Legal Framework ▪ Delhi Med Council Act ▪ Consumer Protection Act ▪ Other State Acts 3. Govt. and Private sector health insurance initiatives (initial stages)	1. Community-based organizations, for instance, Desa Siaga (village alert), PKK (women's group), Integrated Health Posts, and school Education programmes 2. Insurance for the poor 3. Patient awareness - Communication information and education programmes	1 Community - base approach and holistic approach to identify the health problem in each age group and improve the quality of care to raise the reputation of service 2 To educate and mobilize the people to know their right 3 Create self help group and network for illegal migrant, elderly, etc 4. Provide global fund for Illegal migrant, deserved people 5 Collaboration between sectors for proactive care	
Please identify the	Governance issues:	1. CBOs – need	1. Lack professional	

main difficulties related to successful implementation of these initiatives? Provide examples of successes and failures.	1. Lack of political will 2. Corruption in the system 3. Translating legislation into an implementing missionary 4. No accountability Examples of successes: 1. Marwari Mat. Hospital in Guwahati 2. LIP in Kolkata Failures: 1. Absence of recognition of urban poor as group with specific needs and design of programmes FOR the urban poor 2. Focus on averages: disaggregated analysis absent absence of recognition of differences between registered and unregistered slums	strong leadership and some budget 2. Insurance – need proper identification and targeting 3. Needs media channel to reach the people, incl. human resources - Communication, information and education	(no, proper allocation) 2. Discrimination to provide service for the people 3. Has a network between the provider and the community Example of success : 1. case net work between sectors at Samuthprakarn province	

Health Care Seeking and Patient Rights

Chair: Dr.Deoki Nandan. Rapporteur: Yati Soenarto. Members of the group: Sanjay Gupta, Deni Sunjaya, Soenarto Sastrowijoto, Marius Wiojajarta, Corul Anwar, Sakchai, Somsak Lolekha, Sirinard Nipaporn, Bupawan Phuaphanprasert, Reidar Lie

	INDIA1.neglegent+	INDONESIA	THAILAND	Lessons learnt / recommendations/conclusions
What do you see as the three main problems/needs related to health care seeking and patient rights?	1 Low understanding of existing rule regulation in private sector 2 legislation for infrastructure. 3. No separate legislation/ regulation for private sector. Inequality in patient right Lengthy procedure for justice 4. Human right commission, women right commission. 5. Medical council act 6. No: proper guideline, control, evaluation	1. Right: Legislation is available, no implementation Low capacity of the local government. although already decentralization. 2. Difficult to implement the regulation; monitoring, punishment are not recommended/clear. 3. Rights related to private health care is available but not similar across private and public sectors	1.The law is available, but enforced only for private sector all are being controlled → quality is better than the public sector 2. Inequity: limit private in limit/target. Society fix.: not available. Gender equity 2. administrative staff: in private, sector are not MDs, whereas in public sector, they are more MDs	1. There is lack of MONEF (monitoring and evaluation), however, norms are used, Initiative: develop its MOU. 2.Over regulation as bed as under regulation 3.several initiative have been conducted: CPD, research, etc 4. PPP (Private-public partnership) should be developed Compilation of document and dissemination of rules/regulation
Please describe recent/current/planned initiatives have been taken to address these issues, if any.	Abolition of quackery NRHM: • Decentralization • Public-Private Partnership Advocacy by NGO's	Local government and parliament develop act appropriate with local issues Improving local government capacity concerning regulation function.	Research: private should be approved by MOH. Whereas pubic/university can do by themselves. Now improved---less trust. Even color	

		-advocacy fr0m NGO and private	of the private hosp is certain color, given by the MOH	
Please identify the main difficulties related to successful implementation of these initiatives? Provide examples of successes and failures	Corruption and community awareness - Solution: specific regulation and legislation for private sect and independent body for monitoring	Corruption and community awareness Solution: specific regulation and	Policy is always TOP-DOWN → Now, by the initiative of Med. council, all health professional societies creates initiative proposed to the government	

Private health care delivery and quality of care

Chair: Ashok Kumar Rapporteur: Jenifer Lobo Members: Andreasta Meilala, Mubasysyir Hasanbasri, Yuliawati, Anil Purty, Petcharee Reungon, Dounghathai Janchua and Aumnoay Pirunsarn

	INDIA	INDONESIA	THAILAND	LESSONS LEARNT
Three main problems/needs related to private health care delivery and quality of health care	1. Rapid Growth of RMP and Unqualified persons 2. Lack of continued upgradation of knowledge and skills 3. Unequal geographical distribution in rural, urban and remote areas 4. Inadequate linkages with Public health system 5. Lack of standards of quality and fee structure	1. Lack of public health responsibility 2. Rejection of poor patients 3. Uncontrolled/varied fee structure	1. Inaccessibility to poor 2. Lack of monitoring and evaluation 3. Over-treatment and expensive treatment	1. PP need to be involved in the national health challenges 2. Equal Geographical distribution of PP 3. Clearly defined quality of standards and fee structure to be ensured 4. Monitoring and Evaluation system to be defined and ensured
Describe recent planned/current initiative to address these issues	1. Launch of NRHM, and NUHM- infrastructure, delivery of care, quality, outreach with PPP and	1. Licence to practice has been simplified 2. Insurance system extended to PPs so that	1. Social Health Insurance for workers- limited coverage and claim	1.Co-ordination of multiple agencies is a challenge 2. Registration of health

	Public health standards 2. Re-registration of RMP every 5 yrs after CME 3. Orientation of rural medical practitioners 4. Review by GOI of various regulatory councils	poor are served 3. Assignment of specific health care in the community they are serving	2. Licence for doctors and nurses 3. Private clinics and hospitals registered 4 Private hospitals accredited	care workers is possible
3. Identify the main difficulties related to the successful implementation of these initiatives. Examples of a. successes and b. challenges	1. Lack of mobilization of resources to implement NR/UHM in the states 2. Inadequate review by MCI of State councils 3. Inefficient implementation and long drawn out regulatory mechanisms a. Decentralization to district and PRI to ensure PPP b. Implementation due to large population, area, diversified geographic and socio-cultural factors	1. Lack of resource and willingness to participate In public health activities 2. No independent monitoring agency 3. Lack of public agency to follow up complaints 4. Lack of consistency of NGOs to help the poor. 5. Lack of eligibility criteria for poor to be covered by social insurance	1. Lack of Community awareness of benefits of social insurance schemes extended to PPs. 2. Lack of infrastructure to monitor accredited hospitals	1.Monitoring mechanisms are difficult to implement 2. Mobilisation of resources (human and finance) is a challenge.

Health Financing

Chair Rama Baru. Rapporteur: Siddarth Aggarwal. Group members: Laksono Trisnantoro, Yulita Hendrartini, Supasit Pannarunothai, Nilawan Upakdee, Kira Fortune Jensen, Dr Rama Baru, Siddharth

	INDIA	INDONESIA	THAILAND	Lessons learnt / recommendations/conclusions
What do you see as the three main problems/needs related health financing and equity?	Primary care/OPD: The poor mostly go to private, including less qualified practitioners and drug stores	Primary care/OPD: the poor mostly go to Govt facilities and few go the private Hospitalization care: Mostly poor receive	Primary care/OPD: mostly poor go to private facilities, including not so qualified and drug stores	

	Hosp: the poor go to public more often and less often to private	care at public hospital There is a VIP/paid Pvt ward being introduced in most hospitals, which provides more financing to the hospitals and this improves care to the poor as well.	Hospitalization: poor mostly go to public sector	
Please describe recent/current/planned initiatives have been taken to address these issues, if any.	Janani Suraksha Yojana (for delivering women) Health insurance for the poor under NRHM State Govt. schemes e.g. Chiranjeevi scheme - Gujrat	Poor family scheme (National Govt) Social Security System Local Municipal Schemes complementary to those un-insured by 'poor family' scheme	Universal coverage program Focus on infrastructure and manpower	
Please identify the main difficulties related to successful implementation of these initiatives? Provide examples of successes and failures.			Universal coverage scheme for all sections of society: free for all people Mostly curative Separate budget for preventive care No co-payment, completely free Focus on strengthening infrastructure and human resources to bridge gaps Have VIP wards at	Similarities: Mixed service provisioning and financing Access and utilization of services are different across countries Challenges: How to bring doctors to the remote areas? Poor distribution of human resources and infrastructure Poor quality of services deters slum dwellers to avail services

			hospitals to improve overall quality at hospital Thailand made a small increase in taxation which was utilized for providing resources for universalization Enforcement of referral system has helped Thailand to encourage utilization of funds Examples of community based health financing initiatives	Lack of resources on preventive care

Annexure 3: Workship report, Delhi May 08

HSRE
Health System Reform and Ethics

The Private Sector in Public Health: A Solution for the Urban Poor?

Centre for Community Medicine
All India Institute of Medical Sciences, New Delhi

10 May, 2008

Venue:

Board Room, The Constitution Club,
Vithal Bhai Patel House,
Rafi Marg, New Delhi – 110 001

WORKSHOP REPORT

Contents

Objectives

The Centre for Community Medicine, All India Institute of Medical Sciences, New Delhi, organized a workshop on 10 May, 2008 on *The Private Sector in Public Health: A Solution for the Urban Poor?* The main objectives of the workshop were:

- To present the findings of a study in India as part of a multi-country research project on "Health System Reform and Ethics in South and Southeast Asia".
- To discuss specific policy implications of the findings of the study in light of the proposed National Urban Health Mission.

Background

The research project, which was initiated on 1 April 2004 and concluded on 31 March 2008, has been carried out as a collaboration between All Institute of Medical Sciences, New Delhi (India), University of Aarhus (Denmark), Naresuan University (Thailand) and Gadjah Mada University (Indonesia), and funded by the Danida Council for Development Research (FFU), Denmark. The project has studied the role of the private health care sector in poor urban neighbourhoods in Delhi and Bhubaneswar in India, Yogyakarta in Indonesia and Phitsanulok in Thailand.

The main objective of the project has been to identify feasible regulatory mechanisms and strategies for the private healthcare sector to improve quality of care, including for the urban poor, in these countries. Very few studies exist on this topic, and it was observed that the situation varies considerably from country to country, and within countries. The study was designed as a comparative case-study including four cities where a 'case' was constituted by a local, micro-level healthcare system (i.e., a poor neighbourhood).

In each site, four sub-studies were undertaken to:

- understand the ethical and legal frameworks of private practice,
- understand the clinical work and decision-making of private practitioners,
- understand decision-making at household level in poor neighbourhoods,
- assess the economic impact of ill-health and treatment-related practices at the household level.

The project, therefore, supplements an understanding of the patients' perspectives with an understanding of the private practitioners' and drug vendors' perspectives. The policy implications of the findings of this study are significant. Policy briefs have been drafted keeping the different scenarios in Delhi and Bhubaneswar in mind. The policy implications were discussed in the light of the proposed National Urban Health Mission in the India at the workshop reported here.

Presentations

Dr C. S. Pandav welcomed the participants and stressed the importance of establishing an iterative feedback mechanism between research, policy and society.

He highlighted a number of social factors that influence patients' choice of treatment and said that the social sciences are required to understand such factors based on use of qualitative methods and also pointed out that the focus for the project had been private for profit practitioners in low-income urban areas and at the primary health care level. The powerpoint presentation is provided in Annex 3.

Dr Jens Seeberg then gave a brief introduction to the project, including its objectives, organisation and involved partners. He outlined the stress on qualitative methodology, including repeated long-term observation visits in private practitioners' clinics. Also, GIS, survey and desk studies had been included. The slides from the introduction to the project are available in Annex 4.

Dr Nupur Barua, on behalf of the research team at AIIMS, then presented the findings of the Delhi study. Dr Barua's presentation examined the reasons for the overwhelming preference of the urban poor for the individual untrained private practitioners in a slum in Delhi. Expenditure on use of government facilities was found to be more expensive than these practitioners. The modalities of treatment inside these clinics and competence constructions of different practitioners by the care seekers were discussed in a context where the patient struggles to survive and the practitioner thrives by providing health services in situations in which they are most needed. It was observed that qualified medical practitioners were unwilling to set up clinics inside the slum area and that, therefore, there was no genuine alternative to non-qualified practitioners. Therefore, the raids that had been conducted against these so-called 'quacks', were unlikely to have a beneficial public health effect. In addition, the study found that there was not much difference in prescription practices of the qualified and non-qualified practitioners as observed during first consultation, and that in neither case were rational drug use practiced. Rather, ensuring good business by meeting the patients' expectations for quick symptomatic relief was in focus for both groups of practitioners. The slides from this presentation are provided in Annex 5.

The health services available to the poor in Bhubaneswar are markedly different from conditions in Delhi, as was pointed out in Dr Jens Seeberg's presentation. He pointed to the rapid growth of the city, which he divided into centre and periphery, with most health care facilities concentrated in the centre and higher proportions of poor people in the periphery. He then showed that the social dynamics of the small slum studied worked to divide the poor and the very poor in terms of access to drinking water and stressed the need for health insurance and community risk sharing mechanisms that could function in spite of such inequities among the poor. He pointed out that the urban poor in the sampled slum area in fact had access to government facilities, and that these constituted the most used treatment option. However, in many cases, chemist shops functioned as de facto primary health care institutions.
The structure and behaviour of the pharmaceutical industry and its interface with providers and the medical representatives as mediators between the producers, service providers and consumers was discussed. The study showed that fierce competition between pharmaceutical companies led to use of aggressive marketing strategies that was implemented by medical representatives. The key role of the chemists, how they do not have trained pharmacists and how they act as informal agents for the pharmaceutical industry was delineated. Here, the pharmaceutical companies have found effective ways of exploiting the weaknesses of the public sector for their own

benefit, thereby ultimately increasing use of unnecessary drugs and out-of-pocket expenditures. Dr. Seeberg ended by saying that NUHM clearly represents a major leap forward for urban public health and suggested a number of discussion points that could be taken up at the round table discussion. This presentation is available in Annex 6.

Rundtable Discussion

Chair: Dr. G.C. Chaturvedi, IAS, Additional Secretary & Mission Director, NRHM, Government of India
Co-Chair: Mr. Suyash Prakash, IAS, Mission Director, Delhi State Health Mission, Government of India

Mr Suyash Prakash initiated the discussion by taking up the issue of the anti-quackery bill which had been drafted. He suggested a definition of a quack as a person who practiced outside his/her area of expertise, irrespective of which system the person might be trained under. He discussed the need to integrate AYUSH (Ayurveda, Yoga, Unani, Siddha & Homeopathy) but also warned that some conditions had to be treated by allopathic medicine. He mentioned the resistance within different practitioners of AYUSH to mutual recognition of qualifications. He said that the less qualified practitioners in Delhi could be permitted to practice under certain preconditions, including that they only use over-the-counter drugs and that they refer serious cases to qualified practitioners or hospitals. He ended his discussion by stating that the survival of the quacks in Delhi is due to the lack of public primary health care.

Dr G. C. Chaturvedi pointed out that the mega-cities of India also differ markedly in terms of development of the health sector, with Delhi currently having the most difficult scenario. He pointed to the experience from National Rural Health Mission that AYUSH and RMPs (Registered Medical Practitioners) needed to be integrated into the health system for the simple reason that in many places there were none better qualified. He said that perhaps with 3 months training courses they would be able to improve prescription practices and pointed to a current project with RMPs in Bihar. Standard treatment guidelines and protocols should be adopted, but so far these had met huge resistance from the medical fraternity, even if (or because) they could largely improve the services provided by paramedical staff, and that, perhaps, IT could play a role in this context with certain computer programmes being seemingly able to diagnose symptoms with 80% accuracy. He pointed to the huge complexity involved in the urban health system, that also included bureaucratic constrains and that necessitated a very flexible national framework within which different cities had to develop their own models. He mentioned the role of the USHA (Urban Social Health Activist) in the proposed NUHM in the planning and management of health care services in slums and the issue of the number households that should be served by one USHA as a case in point. Dr Chaturvedi then requested from the participants of the workshop that they should provide specific recommendations that could be fed directly into the draft document of the NUHM. He specifically mentioned the complex issues related to the introduction of health insurance that may be linked up with urban health centres and, to the extent necessary, also with private providers and hospitals. The role of insurance companies introduces another level of complexity and

posed new challenges, and the suggestion to introduce smart cards seemed to involve very substantial and potentially insurmountable problems in terms of implementation.

Dr William Aldis, in his comments, strongly discouraged the use of software instead of face-to-face clinical assessment, which he felt would continue to be required irrespective of the quality of software, because the clinical investigation cannot be disregarded in diagnosis. In terms of ensuring increased access to health care, substantial advances could be achieved if the focus was changed from formal qualifications to actual skills, thereby softening the unproductive dichotomy between qualified and non-qualified practitioners. Treatment guidelines and protocols had been proved to be very useful in the context of disease classification and often can help less qualified staff to substantially improve the quality of performance when introduced along with appropriate training. He cited the case of training drug vendors in Nigeria for diarrhoea management in this regard. He stressed that such treatment protocols had to be introduced as part of medical training and that, in his experience, professors at medical colleges appreciated such protocols when their scientific basis was appropriately explained to them. This, he suggested, could over a period of time help overcome the resistance to such protocols among the medical doctors.

Dr. Manoj Kar stressed the heterogeneity of populations in slum areas and intra-slum variations and cited Panschilnagar slum in Bhopal as an example. He also stressed the importance of engaging Urban Local Bodies (ULBs) for improvement of slum areas. While standard treatment guidelines could facilitate better treatment protocols, the important issue would be to determine if they were actually used.

Dr Monica Rana stressed the importance of focussing on existing infrastructure. She suggested that primary health care should be a state level responsibility and recounting her experiences in the field, stressed that secondary care was more appropriate for PPP. In this context, she mentioned that PPP should be initiated only if the partner was found to be credible. She also stressed that community mobilizers were very important and suggested health staff should not be programme linked.

Dr. Sanjay Kumar discussed the need for "regulatory mechanisms to 'check the quacks'" and suggested that government doctors should visit slum areas.

Dr Ritu Priya Mehrotra raised the important issue of similar (symptomatic) treatment being provided by both qualified and non-qualified practitioners, whereas in fact government facilities offered a medically much more appropriate treatment based on rational drug use, which, however, did not meet the consumers' expectations of quick symptomatic relief. She suggested that a realistic category of various providers should be made and stressed the importance of focussing on who is actually providing specific services in specific contexts. She pointed out the need to increase the efficiency of existing services rather than creating new PUHCs. Irrational practices, in particular, inappropriate use of injections by the private practitioners, need to be publicized. She also discussed the issue of NGO selection for PPP and in this regard stressed on the importance of verification of credibility of NGOs, pointing to recent experiences in NGO involvement (and devolvement) in the AIDS field.

Dr. Jens Seeberg then synthesized some of the issues that had been ranged. Taking as a point of the departure the issue of patient satisfaction, he noted that this was not

necessarily as benign as it seemed, since the standard cocktail of drugs being given to ensure this satisfaction - which often includes antibiotics and steroids as had been observed systematically in the study – may have harmful effects *both* because it is often unnecessary and hence represents a superfluous out-of-pocket expense for patients to the benefit of practitioners, chemists and industry *and* because it hides serious symptoms and delays appropriate diagnosis of these cases, sometimes with long-term consequences involving development of chronic conditions. He suggested that the fact that qualified and non-qualified practitioners in Delhi were observed to deliver the same type of treatment was a result of stiff competition and that consumers, if they did not get quick symptomatic relief (i.e., were 'satisfied') would simply move to the next practitioner who would meet the expectations in order to get the business. The implication is, that this unregulated competition does not lead non-qualified practitioners to perform as well as qualified practitioners, but to the contrary that qualified practitioners often may have to perform as poorly (as measured by standards of rational drug use) as non-qualified practitioners in order for their business to survive. In order to address this conflict between patient satisfaction and rational drug use, he suggested the need to explore whether the introduction of simple treatment protocols that would lead to better prescription practices could be linked to the proposed insurance system. The implication is that - irrespective of their formal qualifications but with a necessary minimum of clinical training - only private practitioners who implement a determined set of treatment protocols would be accredited for inclusion in the proposed health insurance scheme. Since inclusion in this scheme ought to be good for business, they would hereby get a financial incentive to adopt more rational prescription practices. In order for this to gradually change public expectations, a critical mass of practitioners should be enrolled, and behaviour change communication about what constitutes a good consultation should be developed. While the discussion was primarily taking the Delhi scenario into account, a similar strategy could be adopted with chemists in Bhubaneswar and with non-qualified practitioners in the periphery of the city. Finally, he concluded by suggesting that the level of PPP could focus more on professional and corporate organisations, thereby promoting self-regulation of their respective practitioners and companies (including in the large pharmaceutical industry in India), and he noted that the roundtable discussion had not been able to address the important problem of household units being suggested as the primary unit for proposed risk pooling and insurance mechanisms in NUHM, thereby risking to leave out the many homeless.

Dr G. C. Chaturvedi concluded the meeting by thanking for the input that had been suggested and by inviting written comments and suggestions for the group in the one/month window that still existed for this purpose.

ANNEX 1: Programme

10.00 - 10.10	**Welcome: Dr. C. S. Pandav**
10.10 - 10.15	Introduction of participants
10.15-10.30	**Health System Reform & Ethics** Project overview: Dr. Jens Seeberg
10.30 - 11.00	Tea/Coffee Break
11.00 - 11.30	**Private Practitioners in Poor Urban Neighbourhoods in Delhi and Bhubaneswar** Dr. C.S.Pandav, Dr. Nupur Barua and Dr. Jens Seeberg
11.30 - 13.30	**Roundtable: Recommendations for the proposed National Urban Health Mission** Chair: Dr. G.C. Chaturvedi, IAS, Additional Secretary & Mission Director, NRHM, GOI Co-Chair: Mr. Suyash Prakash, IAS, Mission Director, Delhi State Health Mission, GOI Facilitators: Dr. C.S. Pandav, CCM, AIIMS, New Delhi & Dr. Jens Seeberg, University of Aarhus, Denmark
13.30 - 14.30	Lunch

ANNEX 2: List of Participants

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16) Dr. Vivek Gupta
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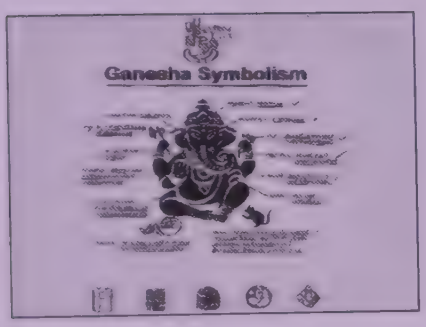
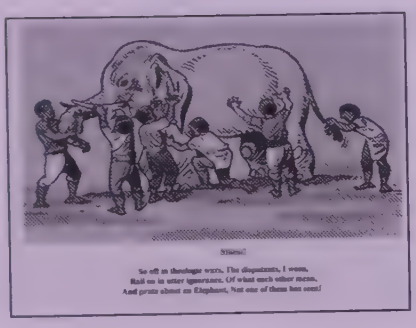
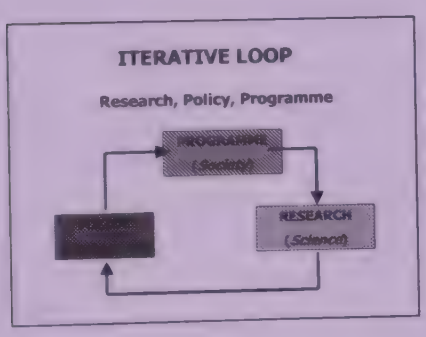
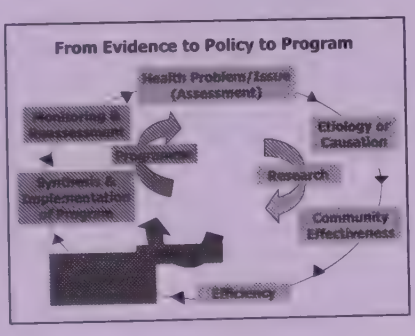
17) Mr. Joe C. Mathew,
Business Standard

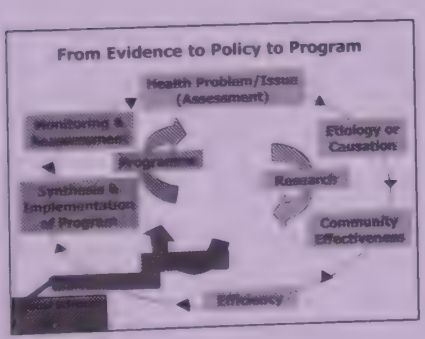
ANNEX 3: Welcome by Dr. C. S. Pandav. Presentation Slides.





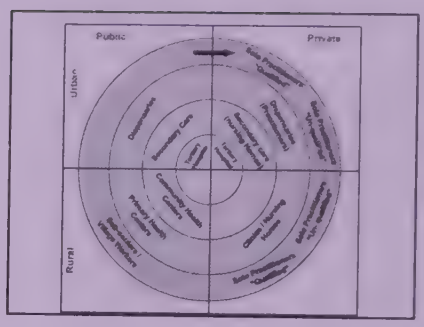






Factors Influencing Choice of Treatment

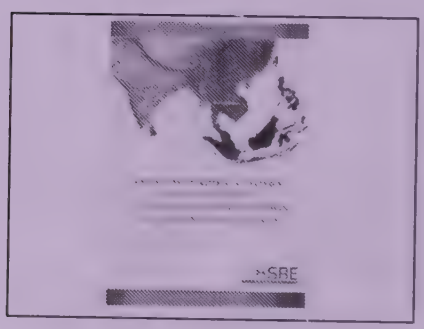
- Shared Exclusion
- Struggle to Survive
- Security
  - Tenure
  - Livelihood
- "Wanting to get back to work"
- Perception of severity of condition
  - "Chota Daktar" / "Bada Daktar"
- Choice of Treatment
  - "Angrezi Dawai" / "Desi Dawai"



I keep six honest serving men
They taught me all I knew
Their names are What, Why, and When
And How, and Where and Who

- Rudyard Kipling

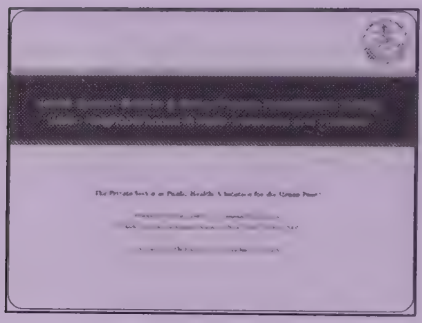
Just - 80 Stories. The Elephant's Child. 1902. Everyman's Library Children's Classics. New York. Alfred A Knopf. 1992. p 79)



Public-Private Mix : A Public Health Fix

ANNEX 4: Project overview by Dr. Jens Seeberg. Presentation slides

11-05-2008



Partners

- All India Institute of Medical Sciences, India
- ICCIDD, India
- Naresuan University, Thailand
- Gadjah Mada University, Indonesia
- University of Aarhus, Denmark

- Funding agency: Danida Research Council (Danish Ministry of Foreign Affairs)

Objectives

- **Main Objective**
  - **To identify feasible regulatory mechanisms and strategies to address iatrogenic health problems in the private healthcare sector, with focus on poor neighbourhoods in selected urban centres in India, Indonesia and Thailand.**
- **Specific Objectives**
  - **To identify systematic constraints in private practice with negative consequences for healthcare, in particular pertaining to treatable infectious diseases;**
  - **To determine constraints for practitioners' and poor patients' treatment-related decision-making**
  - **To identify similarities and differences through comparison of data and findings across centres within and outside the project and describe their health policy implications.**

Project overview

- Project period (India): 01.04.2004-31.03.2008
- Four substudies
  - Health Systems Ethics Among Private Practitioners: Ethnographic Sub-Study
  - Family-Level Decision-Making About Treatment: Interview Sub-Study
  - Household Survey: Health Economics Sub-Study
  - Existing Regulatory Mechanisms, Including Ethical Codes And Legislation With Direct Implications For General Private Practitioners: Desk Study

Emphasis on qualitative methodology and analysis

- **Approx. 2 years of qualitative data collection among poor households in selected slum areas of Delhi and Bhubaneswar AND among both qualified and non-qualified (i.e. without formal qualifications) private practitioners**
- **Methods comprised both repeated series of observations in clinical settings and households and repeated qualitative interviewing with practitioners, patients and relatives concerning treatment practices and health seeking behaviour**
- **Focus on issues of HOW and WHY practitioners and poor families do what they do in pursuing health-related goals**
- **Qualitative data subjected to rigorous coding and thematic anthropological analysis leading to understanding of distinct patterns of social practices**
- **Combined with quantitative health economics survey (HOW MANY, HOW MUCH) (panel data, approx. 200 households in each city, interviewed 3-4 times)**

Findings in context og NUHM

- International workshop held in Thailand in June 07 to discuss findings and policy implications, resulting in specific policy recommendations for each country, including India
- Substantial overlap between these recommendations and the NUHM as discussed in the draft mission document
- Fortunate timing of completion of project and shaping of the NUHM
- Opportunity to compare very different scenarios in two cities from Category A (Delhi) and Category C (Bhubaneswar) as defined in draft NUHM document

ANNEX 5: Private Practitioners in Poor Urban Neighbourhoods in Delhi by Dr. C.S. Pandav and Dr. Nupur Barua. Presentation Slides

Health System Reform & Ethics:
Private Practitioners in a Poor Urban Neighbourhood in Delhi

HSRE

[redacted]

Delhi: An overview

- **Capital city, one of the richest regions in the country**
- **Population: > 13 million**
- **Highest population density in country**
  9224/sq.km vs all India – 324/sq.km
- **Large populations (64.5% of total) live in JJ clusters, slums & unauthorized colonies**
- **Large scale migration**

The study

- **Study site**
  - ***Jhuggi-jhopdi* cluster, S. Delhi**
  - **Population size: ~ 15000**
    majority migrants, wage earners
    (Bihar, UP, Rajasthan, Haryana, Andhra Pradesh)
- **Selection of respondents**
  - **207 households**: household expenditure study
  - **25 households:** in-depth case studies
  - **25 private practitioners:** 18 located in slum, 7 outside

The study

- **Methodology**
  - **Unstructured, & later semi-structured interviews**
  - **Observations: clinic interactions**
  - **Exit interviews of patients, when possible**
  - **Questionnaires: household economy substudy**
- **Constraints**
  - **Raids on nonqualified PPs**
  - **Media reports**
  - **Demolition of slums across Delhi**

Part 1

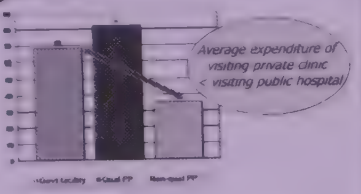
Substudy on:

Health Seeking Behaviour

Midan Puri: Living on the edge

- **Among observed households, at least 1 member from a HH visits a practitioner once every 5 days**
- **> 4/5 visit individual private practitioners in *Jhuggi***
- **Of 471 observed clinical interactions**
  - Majority: Fever, cold, diarrhea, injury, asthma, cough, body pain, weakness, TB, skin problems, mental problems, BP, sexually-transmitted diseases
  - Abortions, mental health problems, HIV/AIDS
  - Repeated surgery after abortions

Avg. expenditure on healthcare



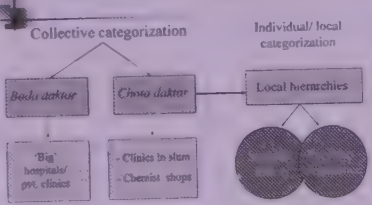
The patients

- Who are they?
  - Patients requiring immediate 'action', basic care
  - Some chronic patients
- What do they want?
  - Situational assessment of best treatment: both cost & quality
  - **Return to work as quickly as possible**

Preferred point of treatment

- **92% cite private practitioner in *Jhuggi* as 1st preference**
- **Of 207 households, only 2 cases (registered during 18m fieldwork) visited government dispensary located 4 km from settlement**
- **Selection informed by contacts, previous experience**
- **Overwhelming preference for biomedical treatment**
  - **medicines/ injections**
- **Level of certification – not a deterrent**

'Hierarchy of competencies'

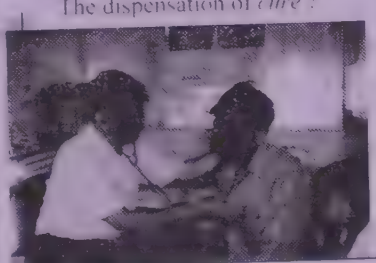


Part 2

Substudy on:

Private Practitioners

The dispensation of *cure* ?



A snapshot…

- **Proliferation of clinics** (Jun 04 - 17, Dec 07 - 27 clinics)
- **Practice:**
  - Location: NQPPs – inside, QPPs – outside
  - 3/4th do not possess formal degrees
  - 80 % 'trained' outside Delhi
- **Associations & networks**
- **Patient load: 10-35**
- **Consultation time: 3-5 min**
- **Payment system**

The practice

- **Focus: 'What the patient wants'**
- **Medicines**
  - Approx. 40% cases medicines given sans examination
  - Mostly: Antibiotics, injections with corticosteroids, tranquilizers
  - Explained in detail:
    - Loose medicines: according to colour, size, shape
    - Medicines in foil: *pudiyas* according to doses
    - Descriptions: "for heart", "for bones", "for tension", "for sadness", "for B P "
  - Doses given according to the amount of money in hand
- **Home visits**

Case 1: Antibiotic for infant diarrhea?

- 4 women carrying infants, all suffering from diarrhea
- PP takes a thermometer dipped in a small bowl of murky water & inserts into the mouth of the infant for 1 min, & places it back in the bowl. He gives the same drugs to all: 6 tablets of Norflox TZ informing tablets be ground, mixed with water & fed to the infant twice a day.
- When researcher questions him about soiled water & infection, the PP says 'there is no such concept [of infection] among children'.
- He does not possess any degrees, says that his knowledge of 'ill health and treatment' (*bimari aur illaj*) is 'inherited'
- When questioned that Norfloxacin is not recommended for children, the PP asks the researcher to leave his clinic.

Case 2: Injection use

- 21 cases of fever observed in consecutive sessions
- In all cases, PP uses a disposable injection, & reuses the same on the next patient
- *The hype over disposable injections is being generated by the media & the 'english company' (manufacturers) to increase sales.*

  Was there AIDS when they had no plastic injections? In the olden days nobody died of using the same injection…so it is a myth.
- 11 patients present in the clinic agree with the PP: *Angrezi doctors use these tools to excuse them from charging more fees*

Comparing NQPP & QPP

- Comparisons of QPPs & NQPPs for fevers (undetermined), diarrhea, dengue, vaginal discharge, TB

Similar prescriptive behaviour of QPP & NQPP on 1st consultation

Qualified vs. Non-qualified

	QPP	NQPP
Time spent	Less	More
Questions asked	Less	More
Physical examination	Less	More
Evaluation of competence	Higher	Lower
Referrals to govt. hospitals	Less	More
Referrals to pvt. hospitals	More	Less
Diff. in what they know & what they do	More	Less

How do they diagnose?

- Experience: chemists, helpers in doctors' clinics & hospitals/nursing homes
- Press releases: current public health issues
- Short-term diplomas in ISM: basic information on human physiology

Aspirations

- Eager to participate in workshops & national programmes
- Research team was constantly asked, towards the end of the project, whether they would assist in training them, acquiring higher skills

Robin Hoods of the *mohalla*

- Only ones 'on the spot' to provide basic primary care
- Seem able to discern complicated cases
- Seem highly aware of health epidemics & media campaigns
- Appear to treat patients with dignity, respect
- Piecemeal medication options: boon for daily-wage earners
- Police raids not the answer – local networks relay information. PPs helped to 'close down', continue practice from next day…

Raids: before...and after

- Before
  - Signboards pulled down
  - Fake registration numbers hidden
- After…
  - *People want to assign blame, and it is better to target doctors like us… even big doctors make mistakes…how many times is that reported in the media?*
  - *There is no point holding a knife….having great degrees … the main thing is are they here?*

THUS, The main issues - NQPPs

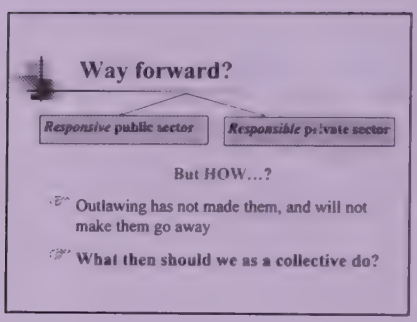
- No legal accountability, few complaints registered
- Referrals
  - To diagnostic facilities
  - Government-run hospitals
  - To other (qualified) doctors
- Similar prescriptive behaviour of QPP & NQPP on 1st consultation

THUS, The main issues- Households

- (Perceived) quality of care drives selection, use of facility
- Competence in public facilities considered higher

  BUT

  'We don't get what we need [in public facilities]'
- Long distances, waiting time, registration procedures, disrespect, loss of wages ⟹ prefer "better care" by NQPPs than "no care" in public facility


Way forward?
Responsive public sector
Responsible private sector
But HOW...?
Outlawing has not made them, and will not make them go away
What then should we as a collective do?

ANNEX 6: Private Practitioners in Poor Urban Neighbourhoods in Bhubaneswar by Dr. Jens Seeberg. Presentation slides

11-05-2008

Health System Reform & Ethics:

Private Practitioners in Poor Urban Neighbourhoods in Bhubaneswar

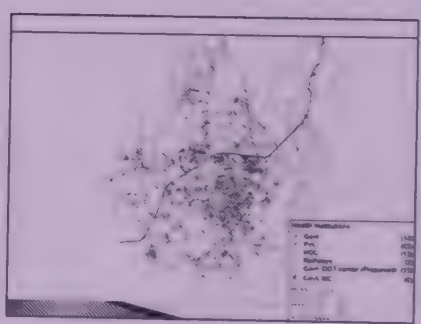
Research team, Bhubaneswar site

Samir Diabagh
Sasmita Sahani
Amita Kanungo
Rosalina Baral
Braj Das
Jens Seeberg

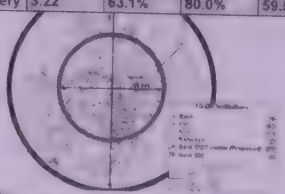
Urban growth in Bhubaneswar

- 17-fold increase in population of Bhubaneswar over 50 yrs
- Rapid growth creates different city-scapes with different populations, facilities and opportunities

Key census 2001 data
- Population = 648,032
- Scheduled Castes = 8%
- Scheduled Tribes = 4.5%
- Illiteracy = 22 %



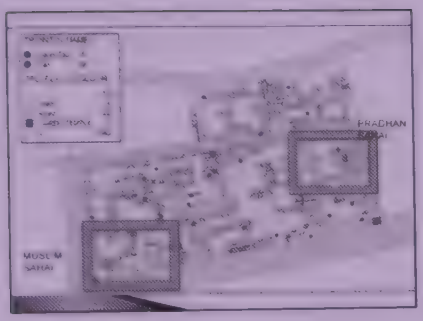
	Avg. % of population by ward	SC distribution	ST distribution	Distribution of illiterate population
Centre	3.24	36.9%	20.0%	40.5%
Periphery	3.22	63.1%	80.0%	59.5%

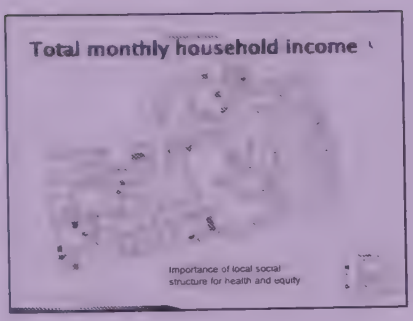


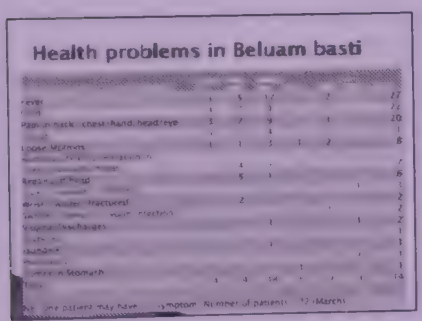
Substudy on health-related behaviour in Bhubaneswar: Beluam Basti

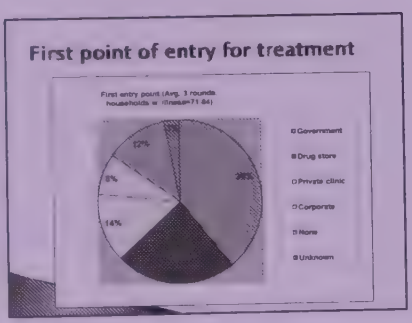
- 520 households
  Population is >2000, mostly SC and ST
  Predominantly Hindu, approx. 30 Muslim and <10 Christian households
- Distinct ST communities include Kondh and Pradhan
  388 families w BPL cards
  The average HH size of 4.3 persons

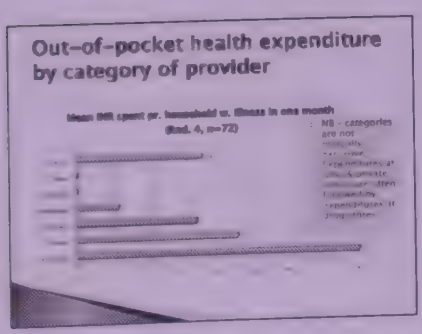
11-05-2008

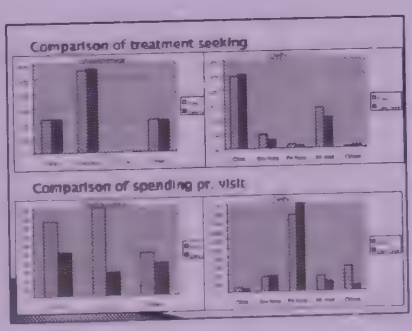

BRADMAN
MUSLIM


Total monthly household income
Importance of local social structure for health and equity


Health problems in Beluam basti


First point of entry for treatment
First entry point (Avg. 3 rounds households = (mean=71.84)
12%
8%
14%
Government
Drug store
Private clinic
Corporate
None
Unknown


Out-of-pocket health expenditure by category of provider


Comparison of treatment seeking
Comparison of spending pr. visit

11-05-2008

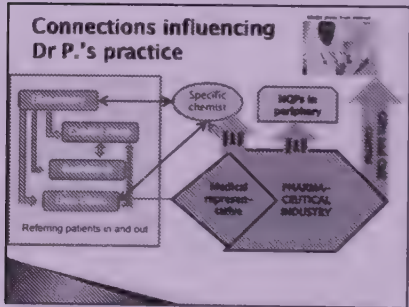
Relevance for NUHM?

- The NUHM policies for community risk pooling and health insurance of utmost importance
- Need to pilot test insurance across different categories of cities
- The organisational unit of Mahila Arogya Samiti seems very appropriate, especially if local social structure is taken into account
- Importance of evaluation at the disaggregate level (i.e. individual sahai in BBSR case)
- How to promote equity across the social divides that exist even among the poor and very poor?
- Rights and the notion of biocitizenship

A Case Story from Bhubaneswar

- Dr P., a medical specialist, has been working in public health system >15 yrs
- Various districts, mostly rural, for 10 yrs. in BBSR
- Married to doctor (specialist)
- Not satisfied with career path, placed in Gov dispensary despite substantial experience
- Also works in Capital hospital once a week
- Runs private practice out of residence
- Has recently set up new clinic in peripheral area of Bhubaneswar
- His new clinic involves a substantial financial burden in terms of bank loan for construction
- He and his wife practice in new private clinic in evenings
- Sees around 20 MRs every day

Connections influencing Dr P.'s practice



Implications

- Dual gov-prvt practice is common and affects out-of-pocket expenditures for the poor
- Patients' reasons for accepting the referral and additional costs include
  - Better timings
  - Less waiting time
  - Shorter distance
  - Experienced increase in quality of services
  - Perceived increase in quality of drugs
- New drugs are introduced through trial-and-error procedure, and pushed via the periphery
- But: Pt. dissatisfaction → Doctor shopping ← No feedback about efficacy and adverse effects

Local (and) Pharma industry

290 drugs on State essential drugs list
30 drugs earmarked for local small-scale industry production

- The locally produced drugs delivered to the government are considered of low quality by chemists and private practitioners and are generally not available in the market
- Policy managed by Industry Department, not Health Department (conflict of interests)

Implications for NUHM

- Public health problem that drug sales constitutes the 'engine of the machine'
- Issue of NUHM accreditation of PPs and enrollment in insurance scheme may need to take the conflict of interest in this dual practice into account
  CME in the hands of the industry – an issue for NUHM?
- How to address the role of the chemist shops as de facto main primary health care institutions and monitoring link between practitioners and industry – is that a public health problem?

11-05-2008

Level of Public–Private partnerships

- Necessary to engage with private sector because of its dominance as a service provider in India
- Experiences with PPPs are largely case-based and focusing on clinical practice
- Is there a need to engage in PPP at a higher level, engaging with the pharmaceutical industry to have it clean up its own act and promote self-regulation?

Some discussion points

- NUHM clearly represents major leap forward for urban public health
- Possible discussion points
  - Pilot-testing of insurance in different categories of cities, taking social structure into account
  - Coverage of HIV-AIDS
  - Household as unit for insurance (vs. biocitizenship)
  - Monitoring insurance impact on practitioners w. dual practice
  - Strengthening of CME at all levels (partnership w. IMA and others)
  - Initiating national level PPPs
  - Moving from drugs and other pharma products as the organizing principle for service delivery to health as the organizing principle?

Thank you for your attention

Annexure 4: Press clippings

Media Relations Activities

for

Centre for Community Medicine
All India Institute of Medical Sciences (AIIMS)

Joint Media briefing

Private Sector in Public Health: Are there Alternatives for the Urban Poor?

&

Quest towards Sustainable and Permanent Solutions to eliminate Iodine Deficiency Disorders in India

Constitution Club,
May 12th, 2008

Communicators India
T- 22 A, 2nd Floor,
Green Park Extension
New Delhi -110016
Ph: 46082436, 26182667
Email: communicatorsindia@gmail.com

Executive Summary

Media relations activities for Centre for Community Medicine - All India Institute of Medical Sciences

Communicators India (CI) targeted the national, regional, and vernacular media in the capital. The following activities were undertaken to achieve appropriate and timely media coverage on the project - ***Health System Reform and Ethics: Private Practitioners in Poor Urban Neighbourhoods in India, Indonesia and Thailand*** **(H.S.R.E.)**

a) Invitations: CI invited health reporters from the print and electronic media. Invitations were also sent to the senior editors and chief reporters of news papers and wire agencies. Consistent follow - ups were done to ensure a decent attendance of media persons at the press conference

b) Press Release: A press release on the findings of the report, and the need for sustainable and permanent solutions to eliminate Iodine Deficiency Disorders in India, was prepared and disseminated in the media on the day of the conference

c) Media coordination and interviews: CI coordinated with journalists at the venue. The briefing was attended by some of the senior health reporters of leading publications in the capital including The Times of India and Hindustan Times. Following the briefing, most of the media persons interviewed AIIMS's spokespersons and project investigator to develop well researched news stories on the study

The above mentioned activities have resulted in excellent media coverage.

The following publications and television channels have covered the media briefing:

• **Print Media**

S.No	Publications	Date	Title
1	The Times of India	13-05-08	Quacks thrive in Delhi slums
2	Hindustan Times	13-05-08	90 pc docs in slums without degrees: study
3	The Hindu	16-05-08	90 per cent of private medical practitioners without degrees
4	Business Standard	11-05-08	Delhi slum dwellers prefer quacks to doctors
5	The Pioneer	13-05-08	Urban poor settlements treated by

			unqualified doctors: Study
6	Mail Today	13-05-08	The poor man's doctor has no formal medical degree
7	The Statesman	13-05-08	90% medical practitioners in slum areas lack degrees
8	Dainik Hindustan	17-05-08	In Hindi
9	Navbharat Times	13-05-08	In Hindi
10	Dainik Hindustan	13-05-08	In Hindi
11	Jansatta	13-05-08	In Hindi
12	Aaj Samaj	13-05-08	In Hindi
13	Virat Vaibhav	14-05-08	In Hindi
14	Desh Bandhu	13-05-08	In Hindi

- **Electronic Media**

S.No	TV Channel	Date	Status
1	Aaj Tak	13-05-08	Covered and aired
2	CNN - IBN		Covered
3	Total TV	12-05-08	Covered and aired
4	India News	12-05-08	Covered and aired
5	ETV	12-05-08	Covered and aired

- All India Radio also aired the story on 13th May 2008 at 7:45 am

- **Online stories**

S.No	Website	Date	Title
1	Headlines India	12-05-08	Non-qualified med practitioners are Robinhood for slum dwellers
2	Yahoonews	12-05-08	90 percent of doctors in urban slums are quacks: AIIMS
3	Indiaenews	12-05-08	90 percent of doctors in urban slums are quacks: AIIMS

Press Release

Majority of private practitioners in poor urban settlements do not possess formal degrees in any system of medicine

Health of mother and child needs special attention; iodine intake very low in the country: AIIMS

New Delhi, May 12, 2008—More than 90% of private practitioners in the urban poor settlement in Delhi do not possess formal degrees in any system of medicine according to the research report released by Centre for Community Medicine, All India Institute of Medical Sciences here today. The report, part of a multi-country, inter-disciplinary research project—Health System Reform and Ethics: Private Practitioners in Poor Urban Neighbourhoods in India, Indonesia and Thailand (H.S.R.E.), has covered 46 private practitioners and 436 households in two poor urban settlements of Midan Puri, Delhi and Beluam Basti, Bhubaneswar (names changed) from April 2004-Dec 2007

Out of 27 private practitioners in New Delhi covered under the study, only 2 possessed a formal degree to practice, while 26 dispensed allopathic medicine 92% of the total households in Delhi cited a doctor in the 'jhuggi' as their first preference for treatment More than 4/5th of the case study households visit individual private practitioners and only 2 cases (registered during 18 months of fieldwork) visited government dispensary located around 4 km from the settlement. These practitioners have active associations and networks with diagnostic facilities. The majority is 'trained' outside Delhi, and the certificates indicating 'Registered Medical Practitioner' are displayed Police raids are not a deterrent at all for them, and pay-offs through local networks enable clinics to function from next day onwards.

"The results point towards the need for having a strong urban health delivery system that takes care of vulnerable groups. There is a need to crackdown strongly on quacks and other unqualified medical professionals," says Prof Chandrakant S. Pandav, Head, Centre for Community Medicine, AIIMS.

In Bhubaneswar, no practitioner with a formal medical qualification practiced inside the settlement. A couple of traditional healers and one Ayurvedic practitioner provided services inside the 'basti'. The main providers of primary health care to the urban poor were found to be drug vendors and chemists, who often engage in diagnosis and replacement of prescription drugs. The pharmaceutical industry plays a huge role in influencing the prescription and dispensing patterns of chemists and medical doctors through networking systems, intensive monitoring of prescription practices and individual outlets, combined with packages of attractive gifts to the most profitable doctors and chemists. Of 188 households, 50% had used the private sector and 40% the government sector as the point of first entry. The private sector was dominated by chemists and drug vendors, accounting for 32% of the total. The access to the government sector was almost entirely limited to one small facility (police hospital).

The main objective of this international collaborative study was to identify feasible regulatory mechanisms and strategies to address iatrogenic health problems in the

private healthcare sector, with a focus on poor neighbourhoods in selected urban centres in India (Delhi and Bhubaneswar), Indonesia and Thailand. Specifically, the project has aimed to identify systematic constraints in private practice with negative consequences for healthcare and determine constraints for practitioners' and poor patients' treatment-related decision-making.

In each country 4 sub-studies were undertaken in order to: (a) understand the ethical and legal frameworks of private practice, (b) understand the clinical work and decision-making of private practitioners, (c) understand decision-making at household level in poor neighbourhoods, and (d) assess the economic impact of ill-health and treatment-related practices at the household level. The research project was carried out in collaboration with the University of Aarhus (Denmark), Naresuan University (Thailand) and Gadjah Mada University (Indonesia). The project was funded by the Danida Council for Development Research (FFU), Denmark.

The above project and its findings are very crucial especially in light of the Ministry proposing to launch a National Urban Health Mission (NUHM) this year. The duration of the Mission would be 2008-2012. All the services delivered under the urban health delivery system will be based on identification of the target groups (slum dweller and other vulnerable groups), preferably through distribution of Family/Individual Health Suraksha Cards.

At the press conference AIIMS' doctors and other experts also emphasised the need for paying more attention to mother and child health. They felt that despite continuous campaigns and advocacy efforts, the iodine intake (which is extremely important for brain development) in the country is dismally low at 51% of the population (NFHS, 2007). Prevalent myths about the production of sufficient quantity of adequately iodized salt and a lukewarm response of the private sector are some of the key factors responsible for that. However other factors have also contributed substantially to the lack of momentum in India's quest towards elimination of IDD. Rather than waxing and waning of favorable statements, actions and measures undertaken by the policy makers India needs sustained political commitment.

For more information, please contact:

Centre for Community Medicine
All India Institute of Medical Sciences
New Delhi
Tel: 011-26588522, 26589470

Amit Jamwal, Binoy Mathew
Communicators India
Tel: 011-26184642, 26182667

The Times of India
May 13, 2008

TIMES CITY

Quacks thrive in Delhi slums

Study Finds Huge Majority Of 'Doctors' Have No Formal Degrees

Risha Chhilangia | TNN

New Delhi: Patients beware. A recent study conducted by the department of community health at AIIMS has found that in one of the most densely populated urban poor settlements in South Delhi, 90% of private medical practitioners did not have formal degrees. However, that did not stop them from being the first point of contact for 92% of the inhabitants.

"We can't ignore these unqualified private practitioners as they are the first point of contact for a large number people living in slums. Outlawing them is not a solution. The challenge is how best to engage them so that they can deliver quality service to people," said Dr C S Pandav, head of the department, community medicine, AIIMS.

The report said the quacks were thriving because people living in urban slums and resettlement colonies had no access to quality healthcare. Further, the slum-dwellers, mostly daily wage earners, wanted quick fix solutions which the quacks provided. "These unqualified private practitioners provide them quick solutions and because of this they don't have to waste a day. We found that going to a government hospital is twice as much expensive than seeing these unqualified practitioners," said Dr Nupur Barua, co-researcher, department of anthropology, University of Aarhus, Denmark.

The report is part of an international intra-disciplinary research project on health system reforms and ethics, covering private practitioners in poor urban neighbourhoods in India, Indonesia and Thailand. The study was conducted over a period of three years from 2004-2007.

The commonest medical conditions treated by these unqualified practitioners were fever, diarrhoea, asthma, TB, weakness, pain etc.

The surprising find was that these people also "treated" sexually transmitted diseases, mental health problems, abortions and surgeries after abortion. And the demand for such practitioners was increasing. "When we started the study there were just 17 unqualified practitioners. Over the span of three years the number has increased to 27. We also found that of these 27 practitioners, just four had a formal degree, and a majority of them were trained outside Delhi. Shockingly, twenty-six of them were dispensing allopathic medicine," said Dr Barua.

Interestingly, these unqualified practitioners are the ones who refer maximum number of cases to government hospitals and their prescription and list of diagnostic tests were more or less the same as prescribed by qualified medical practitioners.

Hindustan Times
May 13, 2008

METRO

90 pc 'docs' in slums without degrees: study

Jaya Shroff
New Delhi, May 12

A RECENT study of the urban slum settlements of Delhi has revealed that a startling 90 per cent private medical practitioners do not have any formal education.

The research, conducted by doctors at All India Institute of Medical Sciences (AIIMS) over three years, showed that of the 207 households studied in one urban settlement in the Capital, 92 per cent people preferred to go to a private practitioner. In only two cases, the people visited government dispensary located four kilometres from the settlements.

> **'The majority is 'trained' outside Delhi and the certificates indicating 'Registered Medical Practitioner' are displayed outside their 'clinics'**
> RESEARCHER

According to the researcher, Professor Chandrakant S. Pandav, head at the Centre of Community Medicine, these practitioners are part of active associations and networks with diagnostic facilities. "The majority is 'trained' outside Delhi and the certificates indicating 'Registered Medical Practitioner' are displayed," he says.

"Another big problem we noted was that the police raids were never a deterrent they always got away by way of pay-offs through local networks, and clinics start functioning from the very next day," says Dr Nupur Barua, co-researcher in the study.

"Among other astounding findings were that there was complete disregard for the use of disposable injections. Of the 21 cases of injection use observed, these private practitioners used disposable injections and used the same on the next patient," she adds.

On being warned about the harmful effects of re-use of injection, Barua says, "They say that the hype over disposable injections is being generated by the media and the 'english companies' (manufacturers) to increase their sales."

Raising fears on the complete absence of a regulatory mechanism and increasing menace of degreeless private practitioners in the slum areas, Dr Pandav says, "There is a need to recognize the reality that formally non-qualified practitioners are providing first contact healthcare to the poor urban slum population. These practitioners have also expressed their desire to play a role in the National Health programmes. The real challenge is how to engage them."

jaya.shroff@hindustantimes.com

The Hindu
May 18, 2008

"90 per cent of private medical practitioners without degrees"

Staff Reporter

- **Research report released by the Centre for Community Medicine at AIIMS**
- **'These practitioners have active associations and networks with diagnostic facilities'**

NEW DELHI: Over 90 per cent of private medical practitioners in an urban poor settlement here in the Capital — where a collaborative research project was conducted — did not possess formal degrees in any system of medicine, according to a research report released by the Centre for Community Medicine at the All-India Institute of Medical Sciences here. The report is part of a multi-country, inter-disciplinary research project titled "Health system reform and ethics: Private practitioners in poor urban neighbourhoods in India, Indonesia and Thailand."

In India the study was carried out by AIIMS in Delhi and the University of Arhus, Denmark, in Bhubaneswar. Ethnographic research was conducted from June 2004 to June 2007 among 46 private practitioners and 436 households in two poor urban settlements of Midanpuri in Delhi and Beluara Basti in Bhubaneswar. The study found that of the 27 private practitioners in the Capital covered under the study, only four possessed a formal degree to practise while 26 dispensed allopathic medicine. Ninety-two per cent of the households in Delhi cited a doctor in the "jhuggi" as their first preference for treatment and only two cases (registered during two years of field work) visited a government dispensary located around 4 km during this period. These practitioners have active associations and networks with diagnostic facilities. The majority are "trained" outside Delhi and often certificates indicating "Registered Medical Practitioner" are displayed in their clinics although most of these certificate bear no registration number.

Business Standard
May 11, 2008

Delhi slum dwellers prefer quacks to doctors

JOE C MATHEW
New Delhi, 10 May

A study has found that 93 per cent of slum dwellers in Delhi rely on quacks as their primary healthcare contact due to social, psychological and economic reasons.

The four-year long study was funded by Denmark's Danida Council for Development Research. The study, conducted by doctors from the All India Institute of Medical Sciences (AIIMS) during 2004-08 in a South Delhi slum, found that of the 207 households, only two preferred to visit the government dispensary located four kilometres from the settlement. The others felt that non-qualified medical practitioners are more humane, more communicative and offer more payment options for daily wage workers.

The study also found that non-qualified medical practitioners as well as qualified doctors prescribed similar medicines for illnesses like fever, diarrhoea, dengue, vaginal discharge and tuberculosis on first consultation. The majority of these quacks were former employees with chemists, clinics or hospitals, the researchers said.

"These quacks are the only ones who are physically present in such urban slums. Enacting laws to prohibit their practice will not make any difference, as even today, they are running their clinics without any legal protection," said C S Pandav, lead researcher and head of community medicine, AIIMS.

"Having realised the ground situation, I feel that the central government's proposed National Urban Health Mission (NUHM) should factor in their presence before framing policies. Until there is a credible alternative, they will continue to play a role in the healthcare delivery network in slum areas," he added. The researchers also quoted Delhi Medical Council estimates to suggest that about 40,000 such non-qualified medical practitioners are functioning as the primary healthcare contact.

According to them, police raids to close down such clinics often prove unsuccessful due to the local support enjoyed by such practitioners.

Besides Delhi, studies were also conducted in Bhubaneswar to understand the healthcare patterns of the urban poor. Bhubaneswar however presented a different picture, with a very low presence of non-qualified medical practitioners. Most of the rural households in the area said that their first point of contact is the local chemist and not the doctor.

Reacting to the study, Suvash Prakash, mission director, Delhi State Health Mission said that two-thirds of Delhi's population of over 11 million live in the slums. "If 80 per cent of these 11 million are being attended to by non-qualified medical practitioners, it is a serious matter," he said.

He added that there are no credible figures for the number of quacks in Delhi and put the number at 5,000.

The Pioneer
May 13, 2008

Urban poor settlements treated by unqualified doctors: Study

Durgesh Nandan Jha | New Delhi

The urban poor settlements in Delhi do not have access to good health facilities. unqualified doctors, who often give wrong treatment, treat most of them. This fact has been brought out by a research carried by the Centre for Community Medicine, AIIMS.

The report, part of a multi-country, interdisciplinary research project – Health System Reforms and Ethics. Private Practitioners in Poor Urban Neighbourhoods in India, Indonesia and Thailand (HSRE), has covered 46 private practitioners and 436 households in two poor urban settlements of Midan Puri Delhi and Beluam Basti, Bhubaneshwar from April 2004 – December 2007.

According to the study out of 37 practitioners in New Delhi only four possessed a formal degree, while 26 dispensed allopathic medicine. Notably, almost 92 per cent of the total households in Delhi cited a doctor in the jhuggi as their first preference for treatment and only two cases (registered during two years of fieldwork) visited a Government dispensary located around four kilometre of the settlement.

"Of 471 clinical observations during the period majority was for fever, cold, diarrhoea, injury, asthma, abortions and the likes. We observed that in more than 40 per cent cases, these non-qualified doctors gave medicine sans examination that included mostly antibiotics, injections with [illegible] ers," said Chan[illegible] Pandav an AIIMS doctor who was a part of the research team.

He said that the non-qualified doctors gave doses according to the amount of money in hand and even agreed on the fact that money can be given later.

About 21 cases were observed in consecutive sessions where the private practitioners were found using a disposable injection and reusing the same on the next patient. When asked, they said that the hype over [illegible]

The research points out that the non[illegible] as comp[illegible] ones. Th[illegible] kinship with the patient. Also most of them referred the patient to the [illegible] hospitals and [illegible]

[illegible] the poli[illegible] clinic and close [illegible] added another member of the research team.

Mail Today
May 13, 2008

The poor man's doctor has no formal medical degree

By **Mail Today Bureau**
in New Delhi

OVER 90 per cent private practitioners in India's poor urban settlements do not have formal degrees in any system of medicine, says a new study.

The report says a large chunk of the population depends on quacks for treatment.

The study was carried out by the Centre for Community Medicine, All India Institute of Medical Sciences (AIIMS), as part of a multi-country research project to identify problems with private-sector healthcare in poor neighbourhoods in urban centres and chalk out feasible regulatory mechanisms.

The study covered two poor urban settlements — Midan Puri in Delhi and Beluam Basti in Bhubaneswar. Of the 27 private practitioners in Delhi, 26 were allopathic 'doctors', but only four of them had a formal medical degree.

A roadside dentist at work

"There is a need to recognise the reality that non-qualified practitioners are providing primary healthcare to the population in urban slums," said Chandrakant S. Pandav, head of the Centre for Community Medicine, AIIMS. "These practitioners also have active associations and networks with diagnostic facilities. Most of them are 'trained' outside Delhi. Outside their clinics, they display certificates indicating that they are registered medical practitioners."

Experts are concerned at the implications of this on primary healthcare since the locals mostly consult these 'doctors'.

As high as 92 per cent of the total households in Delhi cited a neighbourhood doctor as the first preference.

The situation was even more alarming in Orissa. No private practitioner at Beluam Basti had a formal medical qualification.

The main providers of primary healthcare to the urban poor were found to be drug vendors and chemists.

Besides the pharmaceutical industry played a huge role in influencing the prescription and dispensing patterns of chemists and doctors through networking systems, intensive monitoring of prescription practices and attractive gift packages

The Statesman
May 13, 2008

'90% medical practitioners in slum areas lack degrees'

Statesman News Service

NEW DELHI, May 12: In a recent survey conducted by the All India Institute of Medical Sciences (AIIMS) along with the Centre for Community Medicine, it has been revealed that more than 90 per cent of private practitioners in urban poor settlement in Delhi do not possess formal degrees in any system of medicine.

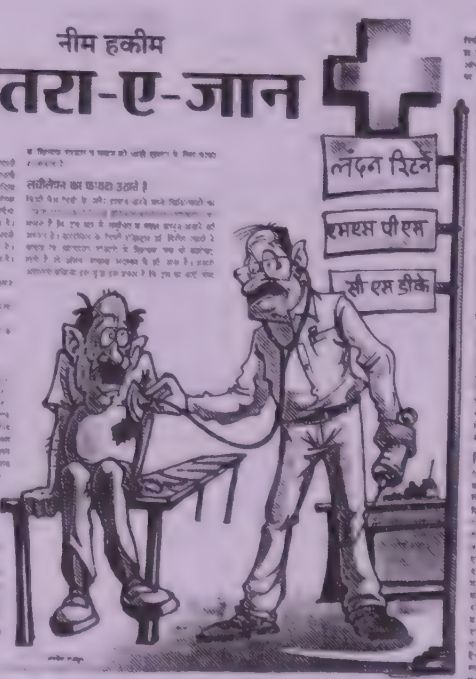
Out of 27 private practitioners in the Capital covered under the study, only four possessed a formal degree to practice while 26 dispensed allopathic medicine. 92 per cent of the total households in slum areas prefer a nearby practitioner for treatment and only two 'patients (registered during 2 years of fieldwork) visited a government dispensary located around 4 km from the settlement.

These practitioners have active associations and network with diagnostic facilities. The majority is 'trained' outside Delhi, and the certificates indicating 'registered medical practitioner' are displayed in front of their clinic. "There is a need to recognise the reality that non-qualified practitioners are providing first contact healthcare to the poor urban slum population formally. These practitioners have also expressed their desire to play a role in national health programmes. The real challenge is now to engage them so that they can deliver quality services to the needy population," says Prof Chandrakant S Pandav, head of the Centre for Community Medicine.

The need for paying more attention to mother and child health was also emphasized at the meet by doctors. They felt that despite continuous campaigns and advocacy, the iodine intake (which is extremely important for brain development) in the country is dismally low at 51 per cent of the population (NFHS, 2007).

Dainik Hindustan
May 17, 2008

तमाम नियम-कानून बनने के बावजूद बिना उचित डिग्री के ही लोगों का इलाज करने वालों की दुकानें चल रही हैं। इन झोलाछापों की वजह से कई लोग जान तक गवा चुके हैं, लेकिन इन पर शिकंजा नहीं कसा जा सका है। ये इधर से उखड़ते हैं, उधर बस जाते हैं। क्या है पूरा मामला, बता रहे हैं अरविंद चतुराज



Navbharat Times
May 13, 2008

बिना डिग्री के ये डॉक्टर हैं या धंधेबाज!

नगर संवाददाता ॥ नई दिल्ली

दिल्ली के पिछड़े इलाकों में प्रैक्टिस कर रहे 90 फीसदी से ज्यादा तथाकथित डॉक्टरों के पास कोई भी मेडिकल डिग्री नहीं है। यह तथ्य एम्स के सेंटर फॉर कम्यूनिटी मेडिसिन की रिपोर्ट से सामने आए हैं। रिपोर्ट के मुताबिक यहां के झुग्गी इलाकों में प्रैक्टिस कर रहे 92 फीसदी डॉक्टर प्राइवेट टेस्टिंग सेंटरों के साथ मिलकर काम करते हैं। ये रजिस्टर्ड मेडिकल प्रैक्टिशनर जैसे सर्टिफिकेट के आधार पर क्लिनिक चलाते हैं। खास बात यह है कि इस सर्टिफिकेट पर कोई रजिस्ट्रेशन नंबर भी नहीं होता।

एम्स की यह रिपोर्ट उस मल्टी-कंट्री रिसर्च प्रोजेक्ट का हिस्सा है, जिसमें भारत, इंडोनेशिया और थाइलैंड के शहरी गरीब इलाकों के हेल्थ सिस्टम रिफॉर्म और एथिक्स के बारे में स्टडी की गई है। इस प्रोजेक्ट के तहत एम्स ने दिल्ली में भी स्टडी की। यह स्टडी जून 2004 से जून 2007 के दौरान की गई। इसके तहत दिल्ली के 27 प्राइवेट प्रैक्टिशनर्स को कवर किया गया, जिनमें से 26 लोग एलोपैथी में प्रैक्टिस कर रहे थे। इनमें से सिर्फ चार के पास फॉर्मल डिग्री मिली। रिपोर्ट के मुताबिक यहां की झुग्गियों में रहने वाले ज्यादातर लोग इलाज के लिए इन्हीं लोगों पर निर्भर हैं, क्योंकि सरकारी डिस्पेंसरी तक पहुंचने के लिए लोगों को कई किलोमीटर की दूरी तय करनी पड़ती है।

NBT राय

गलिन बस्तियों में बिना वैध डिग्री वाले डॉक्टर इसलिए सक्रिय हैं, क्योंकि सरकार वहाँ पर्याप्त संख्या में प्रशिक्षित और वैध डिग्रीधारी डॉक्टर नियुक्त करने में असफल साबित हुई है। झोलाछाप डॉक्टरों पर हाय-तौबा मचाने वाले प्रशिक्षित डॉक्टरों ने भी ऐसी बस्तियों में अपनी सेवाएँ देने के लिए कोई उल्लेखनीय पहल नहीं की है।

दिल्ली के पिछड़े इलाकों में 90 फीसदी डॉक्टरों के पास कोई मेडिकल डिग्री नहीं : एम्स रिपोर्ट

एम्स कम्यूनिटी मेडिसिन सेंटर के प्रो. चंद्रकांत एस. पांडे का कहना है कि इस समस्या से निपटने के लिए रूरल हेल्थ मिशन की तर्ज पर सरकार को अर्बन हेल्थ मिशन भी शुरू करना चाहिए क्योंकि समय के साथ शहरों की आबादी भी तेजी से बढ़ी है।

स्लम एरिया में बड़ी तादाद में लोग रहते हैं लेकिन वहां स्वास्थ्य सुविधाएं बहुत कम हैं। उनका कहना है कि 2008 के अंत तक शहरी स्लम आबादी 6.25 करोड़ तक पहुंच जाएगी। इतनी बड़ी जनसंख्या को नजरअंदाज कर देश की सेहत सुधार पाना संभव नहीं होगा, इसलिए ऐसे क्षेत्रों पर भी पूरा ध्यान देने की जरूरत है। इस रिपोर्ट में डॉक्टरों की कमी से निपटने के लिए रजिस्टर्ड मेडिकल प्रैक्टिसनर्स को ट्रेंड करके उन्हें काम देने की वकालत भी की गई है।

Dainik Hindustan
May 13, 2008

गरीब इलाकों के नब्बे फीसदी चिकित्सक फर्जी

कार्यालय संवाददाता, नई दिल्ली

राजधानी के गरीब इलाकों में मरीजों का इलाज करने वाले 90 प्रतिशत निजी चिकित्सकों के पास वैध डिग्री नहीं है। उनके पास न तो एलोपैथ की डिग्री है और न ही किसी अन्य प्रणाली की।

यह किसी व्यक्ति या संस्था का आरोप नहीं है बल्कि अखिल भारतीय आयुर्विज्ञान संस्थान (एम्स) के सेंटर फॉर कम्युनिटी मेडिसिन की अनुसंधान रिपोर्ट के आंकड़े हैं। हेल्थ सिस्टम रिफॉर्म एंड इथिक्स : प्राइवेट प्रैक्टिशनर्स इन पूअर अर्बन नेबरहूड्स इन इंडिया (दिल्ली, भुवनेश्वर) के तहत किए गए अध्ययन को सोमवार को जारी किया गया। अप्रैल 2004 से दिसम्बर 2007 तक किए गए अध्ययन में 46 प्राइवेट प्रैक्टिशनर और 436 मकानों को शामिल किया गया। रिपोर्ट में यह भी पाया गया है कि गरीब लोगों में आयोडीन की भारी कमी है।

माताओं और बच्चों पर विशेष ध्यान देने की जरूरत है। सेंटर के प्रमुख प्रो. चंद्रकांत एस. पांडव ने बताया कि अध्ययन इस बात को उजागर करता है कि गरीब लोगों की स्वास्थ्य सेवाओं को व्यापक स्तर पर सुधारने की आवश्यकता है।

Jansatta
May 13, 2008

शहरी गरीब बस्तियों में डाक्टरों के पास डिग्री नहीं

जनसत्ता संवाददाता

नई दिल्ली, 12 मई। शहरी गरीब बस्तियों में 90 फीसद से ज्यादा चिकित्सकों के पास औपचारिक डिग्री नहीं है फिर भी वे लोगों को प्राथमिक स्तर पर इलाज दे रहे हैं। अखिल भारतीय आयुर्विज्ञान संस्थान (एम्स) सामुदायिक चिकित्सा केंद्र के अध्ययन में यह तथ्य सामने आए। केंद्र के अध्यक्ष डा. चंद्रकांत एस पांडव ने रपट जारी करने के दौरान कहा कि बेहतर होगा कि इन्हें मान्यता देकर इनकी बेहतर ढंग से ली जाएं।

उन्होंने कहा कि कई देशों में शहरी गरीब बस्तियों में इलाज करने वालों में सुधार और उनकी नैतिक जिम्मेदारी के संदर्भ में शोध परियोजना के तहत भारत के दो शहरों दिल्ली और भुवनेश्वर की स्थिति का अध्ययन किया गया। 46 चिकित्सकों और 436 परिवारों से बात की गई। दिल्ली और भुवनेश्वर में अप्रैल 2004 से दिसंबर 2007 के बीच का अध्ययन किया गया।

दिल्ली के 27 चिकित्सकों से बात की गई इनमें से केवल चार के पास औपचारिक डिग्री थी। बाकी यों ही प्रैक्टिस करते हैं। करीब 92 फीसद लोग प्राथमिकता इन्हीं चिकित्सकों को देते हैं। केवल दो फीसद लोग ही अपने घर से चार किलोमीटर दूर सरकारी डिस्पेंसरी में गए। इन चिकित्सकों ने रजिस्टर्ड मेडिकल प्रैक्टिसनर के बोर्ड भी लगाए हैं। लंबे समय से इलाज कर ये प्रशिक्षित हो गए हैं तो क्यों न इन्हें मान्यता देकर इनकी सेवाएं बेहतर ढंग से ली जाए।

Aaj Samaj
May 13, 2008

छोटा डॉक्टर बड़े डॉक्टर से बेहतर

दिल्ली के झुग्गी पर एम्स की रिपोर्ट

आज समाज, नई दिल्ली

झोला-छाप डॉक्टर (जिन्हें झुग्गियों में छोटा डॉक्टर कहा जाता है), बड़े अस्पतालों के डिग्रीधारी डॉक्टरों (जिन्हें झुग्गियों में बड़ा डॉक्टर कहा जाता है) से कई मायाने में बेहतर हैं। कम से कम सर्दी-जुखाम, आम बुखार जैसी छोटी-मोटी बीमारियों के इलाज के लिए।

यह बात अखिल भारतीय आयुर्विज्ञान संस्थान (एम्स) के सामुदायिक चिकित्सा केंद्र और आयोडीन जनित बीमारियों के नियंत्रण की अंतर्राष्ट्रीय परिषद (आईसीसीआईडीडी) के तत्वावधान में दक्षिणी दिल्ली के एक झुग्गी में किए गए सर्वेक्षण में सामने आई है। सोमवार को केंद्र के प्रमुख डॉक्टर चंद्रकांत पांडव ने इस रिपोर्ट को मीडिया के सामने प्रस्तुत किया। इस मौके पर आईसीसीआईडीडी की कंसल्टेंट डॉ. नूपुर बरुआ और डॉ. अरिजीत चक्रवर्ती भी उपस्थित थे। पंद्रह हजार की जनसंख्या पर किए गए इस सर्वेक्षण में जिस झुग्गी को चुना गया वहां कुल 27 डॉक्टरों में से सिर्फ दो के पास ही वैध डिग्री थी। जून 2004 में जब सर्वे शुरू किया गया था वहां 17 डॉक्टर थे और आज 27 डॉक्टर हैं। सर्वे में बताया गया है कि मरीज इन डॉक्टरों के पास जिन बीमारियों के लिए जाता है उनके लिए ये छोटे डॉक्टर जो दवाएं देते हैं उनमें और डिग्रीधारी डॉक्टरों द्वारा दी जाने वाली दवाओं में कोई खास फर्क नहीं होता। सरकारी अस्पताल और निजी अस्पताल में इलाज करवाने का खर्च 68 रुपए, निजी अस्पताल अथवा क्लीनिक में इलाज करवाने का खर्च 82 रुपए है। वहीं छोटे डॉक्टरों के पास इलाज करने का खर्च मात्र 35 रुपए आता है। सरकार द्वारा प्रायोजित यह रिपोर्ट झोला-छाप डॉक्टरों को मान्यता देने की केंद्रीय स्वास्थ्य मत्रालय के प्रस्ताव को और बल देगी।

Virat Vaibhav
May 14, 2008

गरीब बस्तियों में 90 फीसदी डॉक्टर फर्जी

एम्स के डॉक्टरों द्वारा किये गये शोध से हुआ खुलासा

■ संवाददाता

नयी दिल्ली। दिल्ली के गरीब बस्तियों में करीब 90 फीसदी प्राइवेट डॉक्टर झोलाछाप के तौर पर फर्जी डिग्रीयों के सहारे प्रैक्टिशकर लोगों का इलाज कर रहे है।

यह नतीजा एम्स के डॉक्टरों द्वारा किये गये एक शोध से सामने आया है। लेकिन ताजुब की बात यह है कि अध्ययन के अनुसार करीब 92 फीसदी लोग इन्हीं प्राइवेट डाक्टरों से ही इलाज कराने में दिलचस्पी दिखाए।

एम्स के सेंटर फॉर कम्यूनिटी मेडीसिन द्वारा हेल्थ सिस्टम रिफार्म एंड एथिक्स विषय पर दिसम्बर 2004 से नवम्बर 2007 के बीच अर्बन पुअर स्लम बस्तियों में एक सर्वे किया गया। जिसमें दिल्ली के एक बस्ती के 207 घरों में लोगों से सर्वे किया गया। इस स्टडी के नतीजे आये कि आसपास की डिस्पेंसरियों में जाने की बजाय तकरीबन 92 फीसदी लोग प्राइवेट डाक्टरों से ही कराना पसंद करते है।

जबकि महज 2 फीसदी मामलों में ही लोग डिस्पेंसरियों में जाने की बात कहीं। सेंटर के प्रमुख प्रो. चंद्रकांत एस. पांडव ने बताया कि इन स्लम बस्तियों में 90 फीसदी डाक्टर बिना रजिस्टर्ड मेडिकल प्रैक्टीशनर सर्टिफिकेट के ही प्रैक्टिश कर रहे है। प्रो. पांडव का कहना कि ये डाक्टर बाजारू जांच सेंटरों से तालमेल कर अपनी जड़ें लोगों में गहरी जमा लिये है।

बस, आवश्यकता यह है कि इन डाक्टरों को किस तरह से लोगों की सेवाओं के लिए उपयोगी बनाया जाय। इसी शोध के एक अन्य सहायक प्रो. अनुप बरूआ ने कहा कि सबसे ज्यादा मुसीबत यह है कि पुलिस का धर-पकड़ भी इन इलाकों में कोई बदलाव नहीं ला सके है। क्योंकि ये डाक्टर पुलिस से मिलीभगतकर छूट जाते है और फिर धड़ल्ले से क्लीनिक चलाते है।

प्रो. बरूआ ने इस मौके पर बताया कि ये डाक्टर जाली रजिस्ट्रेशन सर्टिफीकेट भी दिखाने के लिए इस्तेमाल कर रहे है। ■

Desh Bandhu
May 13, 2008

92 फीसदी झुग्गीवासी झोला छाप डॉक्टरों पर हैं निर्भर

नई दिल्ली, 12 मई (देशबन्धु)। राजधानी के झुग्गियों में रहने वाली 92 फीसदी आबादी इलाज के लिए झोला छाप डॉक्टरों का सहारा लेती है। यह खुलासा अखिल भारतीय आयुर्विज्ञान संस्थान (एम्स) द्वारा किए गए एक सर्वे रिपोर्ट में हुआ है। चार वर्षों के दौरान एम्स द्वारा किए गए इस रिपोर्ट में झुग्गी-झोपड़ी व स्लम इलाकों में 90 फीसदी झोला छाप डॉक्टर रहते हैं।

एम्स के कम्यूनिटी मेडिसीन विभाग के विभाध्यक्ष प्रो.चन्द्रकांत एस पांडव का कहना है कि यदि इन डिग्री रहित डॉक्टरों को ठीक से प्रशिक्षण दिया जाए तो आम जनता को प्राइमरी स्तर पर अच्छी स्वास्थ्य सुविधाएं दी जा सकती हैं।

रिपोर्ट में उल्लेख किया गया है कि नई दिल्ली के 27 प्राइवेट डॉक्टरों पर किए गए सर्वे में केवल

■ झोला छाप डॉक्टरों को प्रशिक्षण देने से प्राइमरी हेल्थ सेक्टर में हो सकता है सुधार : एम्स रिपोर्ट

चार डॉक्टरों के पास ही उचित डिग्री थी। ये झोला छाप डॉक्टर स्लम इलाके में रहने वाले लोगों के बीच अच्छा नेटवर्क बना लेते हैं और आम जनता के बीच घुल-मिल जाते हैं।

एम्स के कम्यूनिटी विभाग के विभागाध्यक्ष प्रो.चन्द्रकांत एस पांडव का कहना है कि डिग्री रहित ये डॉक्टर स्लम व झुग्गी-झोपड़ी इलाके में आमलोगों को प्राथमिक चिकित्सा सुविधा उपलब्ध कराते हैं।

इन डॉक्टरों ने राष्ट्रीय स्वास्थ्य योजनाओं में अपनी महत्ती भूमिका निभाने की इच्छा प्रकट की है। प्रो.पांडव का कहना है कि सबसे बड़ी चुनौती इन डिग्री रहित डॉक्टरों को कैसे अच्छा प्रशिक्षण दिया जाए, ताकि आम जनता को अच्छी चिकित्सा सुविधा मिल सके।

यदि ये डॉक्टर प्रशिक्षित हो गए तो देश में प्राइमरी स्तर पर डॉक्टरों की कमी दूर हो जाएगी।

ज्ञात हो कि राजधानी की डेढ़ करोड़ जनसंख्या का लगभग 67 फीसदी आबादी स्लम, अनाधिकृत कॉलोनी,पुनर्वास कॉलोनी, झुग्गी-झोपड़पट्टी और ग्रामीण इलाकें में रहती है।

और इन इलाकों में हजारों की संख्या में झोलाछाप डॉक्टर रहते हैं। एक अनुमान के अनुसार दिल्ली में झोला छाप डॉक्टरों की संख्या लगभग 40 हजार के करीब है।

HEADLINES INDIA
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CURRENT, CREDIBLE, CONSISTENT NEWS

By Geetanjali Atri
Monday, May 12, 2008 (20:44:15)

Non-qualified med practitioners are Robinhood for slum dwellers

New Delhi: Centre for Community Medicine, All India Institute of Medical Science (AIIMS) on Monday released its research report, 'Health system reform and ethics: Private practitioners in poor urban neighbourhood, in India, Indonesia and Thailand' - part of a multi-country and inter-disciplinary research project.

According to Chandrakant S Pandav, Head of community medicine department, "More than 90 percent of private practitioners in an urban poor settlement in Delhi do not possess formal degrees in any system of medicine, but they are the most cheaply and readily available with primary medical assistance".

The extensive research that covered 46 private practitioners and 436 households in two poor urban settlements of Midan Puri, Delhi and Beluam Basti in Bhubaneshwar (names changed) was conducted from April 2004 - Dec 2007. The findings of the research report are nothing new, but clarifies and further intensifies what already exists at the back of our mind. The report says:

For sample diseases like Fever, Cold, Diarrhea, Asthma, Cough, Body pain, Weakness, Tuberculosis, Skin problems, Mental problems, BP and sexually transmitted diseases, a qualified medical practitioner charges Rs 82, a government facility comes for Rs 68, whereas a non-qualified private practitioner givers medication in Rs 32, which is less-than-half of government charges. Thus, poor slum dweller have to opt for the latter one.

While it is the prime responsibility of the government agencies to provide basic care amenities to the poor, the rural slums run barren of any government doctor and the non-qualified medical aid providers are always on the fore-feet to even provide them home-visit in as much money as they can provide.

Approximately, 40 percent cases medicines are given sans physical examination at such private clinics in slums. Examinations are done only when it is requested or demanded by

the patient. As a result, the doctor prescribes 'Norfloux' for diarrhea of an infant and can even go to the extent of using twice the disposable syringe, due to which the sufferers are at high risk of HIV-AIDS.
Poor people also prefer the slum based non-qualified doctors as they treat them with dignity and respect, whereas they get dog-like treatment at government and private hospitals.

Another member of the research team, Nupur Barua, though refrained from commenting upon the level of accuracy of non-qualified and their qualified counterparts, when quizzed by Headlines India, said, "Non-qualified ones spend more time in consultation, but have lower level of competence, when compared with qualified private practitioners."

Despite the health initiatives proposed by the United Progressive Alliance government at the Centre, which includes raising public spending on health sector to at least 2-3 per cent with a special attention to the poorer sections, according to the research report, there still remains a need for the public sector to be more responsive and private sector to be more responsible.

YAHOO! NEWS INDIA BETA

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90 percent of 'doctors' in urban slums are quacks: AIIMS

Indo Asian News Service

Mon May 12 11:06 PM

New Delhi, May 12 (IANS) At least 90 percent of the 'doctors' in slums of Delhi and Bhubaneswar don't have fo according to a survey by the All India Institute of Medical Sciences (AIIMS) Monday

Of 27 private practitioners in New Delhi covered under the study, only four had a formal degree to practice wh dispensed allopathic medicines. At least 92 percent of the households in Delhi surveyed cited a doctor in the first preference for treatment and only two visited a government hospital located around four km away. 'These have active associations and networks with diagnostic facilities. The majority are 'trained' outside Delhi and th indicating 'Registered Medical Practitioner' are displayed,' the survey revealed. Chandrakant Pandav, head of community medicine at AIIMS said: 'There is a need to recognise the reality that non qualified practitioners are contact healthcare to the poor urban slum population.' 'These practitioners have also expressed their desire to national health programmes. The real challenge is how best to engage them so that they can deliver quality se needy population,' Pandav added. In Bhubaneswar, the survey did not find any practitioner with a formal medi qualification. A couple of traditional healers and one Ayurvedic practitioner provided services inside slums. 'Th providers of primary health care to the urban poor were found to be drug vendors and chemists who often eng diagnosis and replacement of prescription drugs,' the survey carried between April 2004 and December 2007. study found that the pharma industry plays a huge role in influencing the prescription and dispensing patterns and medical doctors through networking systems, intensive monitoring of prescription practices and individual combined with packages of attractive gifts to the most profitable doctors and chemists.

Annex 5: Training Report

Training of Research Assistants
All India Institute of Medical Sciences, New Delhi
7 – 13 July 2004

INTRODUCTION

This report provides a summary of the training programme that was conducted for research assistants at the All India Institute of Medical Sciences, New Delhi through 7-13 July 2004. The objective of the programme was to train the research assistants in qualitative research and methodology for sub-studies 2 and 3 of the project on *Health Systems Reform and Ethics: Private Practitioners in Poor Urban Neighbourhoods in India, Indonesia and Thailand*.

PROGRAMME

The agenda was framed on the basis of discussions with the project team during the second project workshop in Aarhus, Denmark in June 2004. It was decided at the workshop that the research assistants, at the end of the training, should be able to:

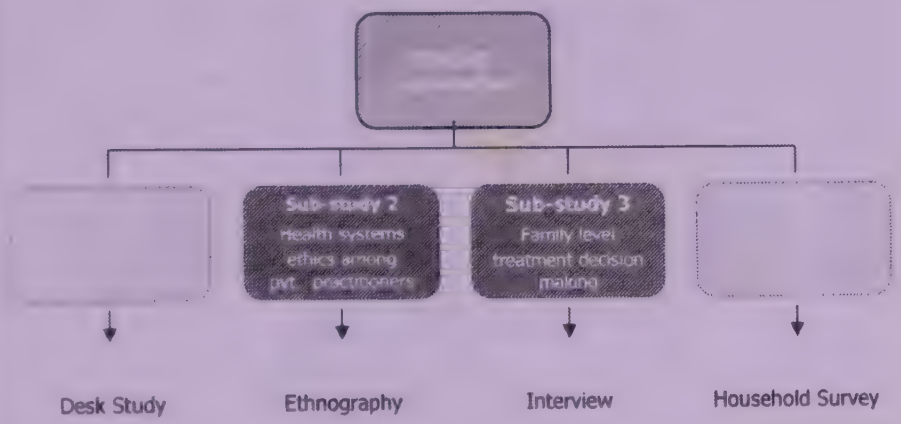
- Understand the project and effectively present the project to participants in the field
- Understand the basics of narrative approach to interviewing
- Understand the concept of bias and the relationship between observation and interviewing
- Under the supervision and guidance of the Co-PI, conduct unstructured and semi- structured interviews with private practitioners and patients/families
- Conduct participant observation in the field
- Create field notes, according to the prescribed format
- Transcribe interviews and field notes according to the prescribed format
- Understand issues of research ethics (in particular, verbal informed consent, confidentiality and protection of data and how to deal with ethical dilemmas in the project)
- Manage the technical equipment as necessary

The focus of the training was on qualitative research and methods. Sub-study 2 was given special emphasis with the understanding that the research assistants would begin sub-study 3 in August 2004 after additional training at that time.

The training schedule comprised a series of didactic sessions accompanied by many practical exercises and mapping of selected field sites using PRA methods. Most of the practical sessions revolved around role playing and conducting interviews, note taking and making transcriptions of the interviews. These sessions were subsequently analyzed and discussed in the light of the presentations made.

The following pages provide a summary of the presentations made during the training.

PRESENTATION 1: INTRODUCTION TO THE PROJECT	
Objectives Main objective: Specific objectives:	To identify feasible, regulatory mechanisms & strategies to address iatrogenic health problems in the private health sector, with a focus on poor neighbourhoods in selected urban centres in India, Indonesia and Thailand To identify systematic constraints in private practice (with negative consequences for healthcare), in particular, pertaining to treatable infectious diseases To determine constraints for practitioners' & poor patients' treatment-related decision making To identify similarities & differences through comparison of data & findings across centres, & describe their health policy implications
Background and rationale	India: Health equity – unequal access to health care Urban poor - unmet health needs & severe financial barriers Better off patients benefit more from public healthcare; poor often left with the private sector, esp. in areas with limited/no access to public facilities, such as urban slum areas Huge proportion of urban poor uncovered by health insurance Out-of-pocket payments for health care 58-86% patients in need of ambulatory care turn to private practitioners as first option Thailand: poor spend relatively large proportion of income on healthcare without getting 'value for money'
The private health sector in south and south-east Asia	Pvt. sector: large proportion of healthcare Pluralism; high degree of syncretism Fierce competition between providers Focus on customer satisfaction, often leading to ill-advised medical consultations Disease-specific studies point to adverse health consequences of private sector treatment (treatment regimens, overdose/ misuse of drugs, etc.) Although private sector holds key to massive improvements in healthcare delivery, there is little consensus on HOW to improve the situation Important – there are only few existing studies of private healthcare Therefore, overall purpose of this study – work out viable strategies to strengthen ethical practice in the private healthcare sector in poor urban areas Focus: feasibility, local acceptability of control mechanisms and other possible means
Methodology	↓ Understanding of the patients' perspective supplemented by an understanding of the private practitioners' perspectives ↓ Health ethics, in this connection, may be broadly understood as a consensus-based normative regulatory framework that primarily works to protect patients against iatrogenic adverse effects of utilizing the health system. At present, such a framework not in place/not working to the desired effect. Also regional/country variations ↓ Therefore, systematic mapping of scenario, based on a

	comparative case study for selected cities in India, Indonesia and Thailand ↓ A 'case' - constituted by a local, micro-level healthcare system (i.e. a 'neighbourhood') ↓ Descriptive study in selected neighbourhood ↓ 4 substudies - to provide a detailed, multi-faceted understanding of the local health system ↓ Analysis of one will inform the analysis of the others ↓ Comparisons across sites and centres
	
Entry into the field	• Selection criteria: access potential, maximum no. of clinics/ variability of types of medicine, minimal practical barriers to carrying out study • Mapping – using PRA methods • Establishing contact – all private practitioners contacted personally for inclusion in study • Compensation – symbolic payment be given as compensation for time invested • Focus: contextual factors, decision making processes, & underlying ethical values in the clinics of private practitioners
Sub-study 2	
Focus	• Observed clinical practices and interactions • Nature & distribution of the actors network connected with individual clinics; roles & tasks • Economic situation of the clinic • Perception of influence, if any, of existing regulatory mechanisms/ethical codes on clinical interaction • Perceived ethical dilemmas & guiding ethical values according to private practitioners • Barriers to/strategies for increasing quality of care • Possible involvement/motivations of relevant actors in improving quality of care
Data generation techniques	Repeated participant observation in clinic Minimal intrusion during doctor-patient interactions Jottings & scratch notes be expanded to field notes on a daily basis, outside the clinical context Extensive note taking be avoided

	Combination of unstructured & semi-structured interview techniques Capture 'emic' terms Later stages: use of an audio recorder, to the extent possible
Sub-study 3	
Focus	Health implications of visits to private practitioners at individual/family levels Users' perceptions of locally available healthcare system Available options, choices, factors Decision making process (who, how, why, when) with regard to illness episodes Resources mobilized for healthcare (past, present, future) Perceived socio-economic consequences of current/previous illness episodes Treatment practices: Perceptions Strategies Options (incl. self treatment)
Methodology	Approximately 25-30 patients/families Interviewed in regular intervals Followed over 12-month period, to gather information on: perceptions, treatment choices, development of illness episodes, and decision making processes Home visits Use of unstructured & semi-structured interview guides Observations Note taking Audio recording Translations & transcriptions
Data analysis	Independent data analysis from each site Use of QSR NVivo software package for coding and analysis of data Sharing data throughout project period on First Class e-conferencing system Transcriptions and coding shared across centres Coding and analysis to be done by Co-PI
Research teams and time schedule for study: An overview	

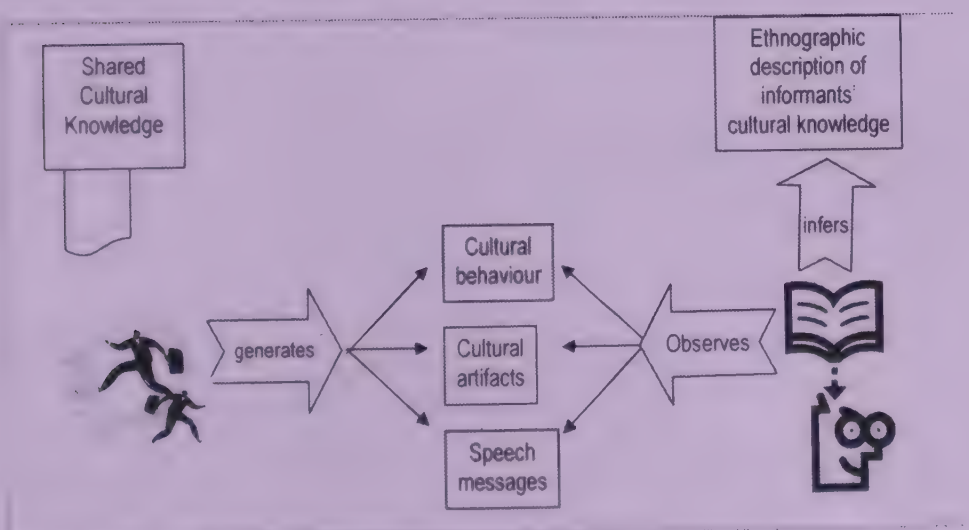
PRESENTATION 2: QUALITATIVE RESEARCH	
Nature of qualitative research	Involves collection, analysis & interpretation of data (that are not easily reduced to numbers) These data relate to the social world & the concepts & behaviors of people within it Perspective: what people perceive or believe is the basis for their actions All qualitative data are context related Therefore, particularly helpful to policy makers & planners by providing descriptive information & and understanding of the concept
Basic assumptions of the qualitative research	Inductive approach to research – from case to theory Contextualized research

paradigm	Holistic and comprehensive perspective The researcher as an instrument – what does the researcher bring to the table, incl. motivations & biases, how they impact on the processes of the study and its results, the relationship between the researcher and the respondents The language of qualitative research
Issues in qualitative research (QR)	QR explores people's subjective understandings of their everyday lives Developing questions in QR: conceptualization as an ongoing process Variables that 'grow': Identifying variables and emergence of variables throughout the processes of data collection and analysis Gaining access and developing relationships Issues of validity and reliability
Key features in QR	One of its key strengths: studies people in their natural settings rather than in an artificial or experimental one Kirk and Miller (1986) define qualitative research as a "particular tradition in social science that fundamentally depends on watching people in their own territory, and interacting with them in their own language, on their own terms". A 'multi-method' approach: often employs several different methods. Watching people in their own territory thus entails observing, joining in (*participant observation*), talking with people (interviews, group discussions and informal chatting), and sometimes, reading what they have written Examples of social phenomena studied within the health care context: patients' compliance with treatment, decision making by health care professionals, organization of the hospital clinic, etc.
QR methods: Strengths and weaknesses	Gaining access to sensitive issues, flexibility, a holistic perspective, prior identification and definition of variable not necessary Indications and contra-indications for using them exclusively or in combination with quantitative research
Data sources: *a. People* *b. Phenomena*	People as repositories of knowledge, evidence and experience Focus: Experiences, accounts, interpretations, memories, opinions, understandings, thoughts, ideas, emotions, feelings, perceptions, morals, behaviours, practices, actions, activities, conversations, interactions, faith, humour, products, relationships Focus: Speech, language, narratives, stories, visual images, diagrams, photographs, maps, texts & publications, media products, laws, statutes, rules, regulations, documents, archives, policies, collectivities, groups, clubs, organizations, events, socio-geographical locations
Qualitative vs. quantitative methods	Can be complementary, rather than contradictory and competitive methods An unfortunate inference: "because qualitative research does not seek to quantify or enumerate, it does not 'measure'"

	Possible to analyze certain types of qualitative data quantitatively Whilst it is true that qualitative research generally deals with talk or words rather than numbers, this does not mean that it is devoid of measurement, or that it cannot be used to explain social phenomena. More often, the insights provided by qualitative research help us to interpret or understand quantitative data more fully; validates quantitative research or provides a different perspective on the same social phenomena; and sometimes, a major reinterpretation of quantitative data. Examples: a. Stone and Campbell (1986) found that cultural traditions and unfamiliarity with questionnaires led Nepalese villagers to feign ignorance of abortion and family planning services and to under-report their use of contraception and abortion when responding to surveys b. Morgan and Watkins' (1988) research on cultural beliefs about hypertension has helped to explain why rates of compliance with prescribed medications vary significantly amongst and between white and Afro-Caribbean patients
Measurement in QR	Measurement in qualitative research usually concerned with taxonomy/ classification Qualitative research answers questions such as, *what is X, and how does X vary in different circumstances, and why?*, rather than *how many Xs are there?* It is concerned with the *meanings* people attach to their experiences of the social world and how people make sense of that world. Therefore, tries to interpret social phenomena (interactions, behaviours, etc.) in terms of the meanings people bring to them Researcher frequently has to question common sense assumptions or taken for granted ideas.
Links between theory and method	The terms 'qualitative research' and 'qualitative methods' are often used interchangeably, but, strictly speaking, *research methods* refer to specific research techniques used to gather data about the social world (such as questionnaires in survey research, or focus groups, and so on) The choice of research method is typically informed by a *research strategy* or a set of decisions about the research design and by beliefs about how the social world can be studied Often, the choice of a particular research method is also inextricably linked to a particular *theoretical perspective* or set of explanatory concepts that provide a framework for thinking about the social world and inform their research Qualitative research is designed to reveal a target audience's *range of behaviour* and the *perceptions that drive it* with reference to specific topics or issues. It uses in-depth studies of small groups of people to guide and support the construction of hypotheses. The results of qualitative research are *descriptive rather than predictive*

	Emphasis: (i) The way in which people articulate their ideas, and (ii) the substance of what people say
Why qualitative research works	Synergy among respondents, as they build on each other's comments and ideas. Dynamic nature of the interview or group discussion process, which engages respondents more actively than is possible in more structured survey. Opportunity to probe (for example: *Help me understand why you feel that way...*), enabling the researcher to reach beyond initial responses and rationale. Opportunity to observe, record and interpret non-verbal communication (i.e., body language, voice intonation) as part of a respondent's feedback, which is valuable during interviews or discussions, and during analysis. Opportunity to engage respondents in 'play' such as projective techniques and exercises, overcoming the self-consciousness that can inhibit spontaneous reactions and comments.

MAKING CULTURAL INFERENCES



Adapted from: Spradley, 1980: 11

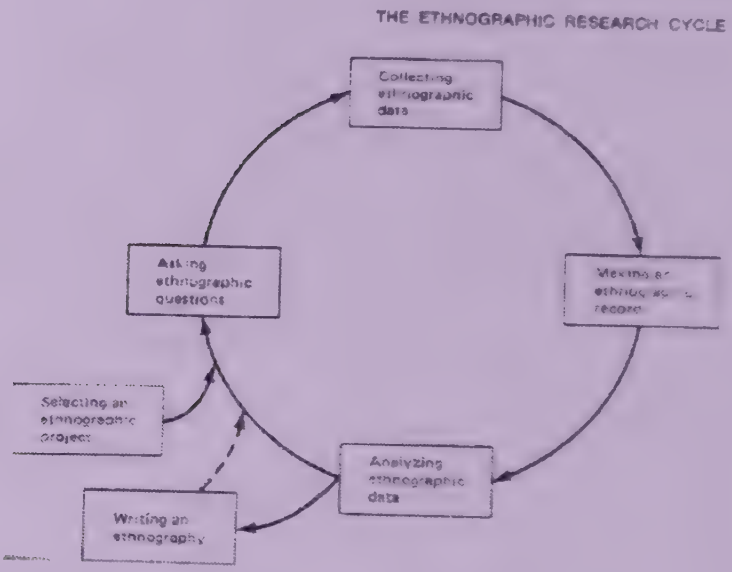
RESEARCH PATTERNS

A: The Linear Sequence in Social Science Research

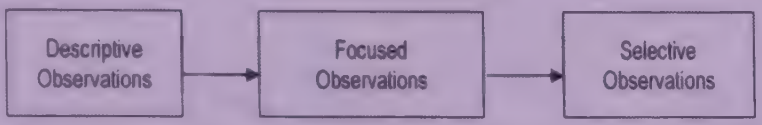
(Spradley, 1980: 27)

- Step 1: Define a research problem
- Step 2: Formulate Hypotheses
- Step 3: Make operational definitions
- Step 4: Design a research instrument
- Step 5: Gather the data
- Step 6: Analyze the data
- Step 7: Draw conclusions
- Step 8: Report the results

B: The Ethnographic Research Cycle
(Spradley, 1980: 29)



PRESENTATION 3: QUALITATIVE METHODS	
Primary methods	↓ Participation in the setting – depending on possible extent/intensity of participation ↓ Direct Observation ↓ In-depth Interviewing ↓ Document Review
Participation	Developed through anthropology & ethnography Both an overall approach to inquiry & a data gathering method Essential element of all qualitative studies, to whatever extent possible Involves 1st hand involvement in the social world chosen for study Immersion allows researcher to see, hear, and experience reality as participants do Ideally, considerable time spent in the setting
Observation	Entails systematic noting & recording of events, behaviors, artifacts in the social setting Assumes behavior is purposive & expressive of deeper values & beliefs - meaning Range from highly structured, detailed notation of behavior (guided by checklists) to more holistic description of events and behavior Motive: To learn about meanings attached to behaviors and objects Fundamental/ critical method in all qualitative inquiry Used to discover complex interactions in natural social settings Body language, affect, person's words, objects, etc.

<table>
<tr><td colspan="2">Making observations
 

Stage 1: Broad areas of interest, without pre-determined categories or strict observational checklists
Stage 2: Patterns are identified & described through early analysis of field notes
Stage 3: Focused observation – check analytic themes to see, for e.g., if they explain behavior & relationships over a period of time/ in variety of settings</td></tr>
<tr><td>In-depth interviewing

Types

Use in the project

Aide Memoire</td><td>Conversations with a purpose (Burgess: 1984: 102)

Patton (1990: 280-290) categorizes into 3 general types:
↓ Informal Conversational Interview
↓ General Interview Guide Approach
↓ Standardized Open-ended Interview

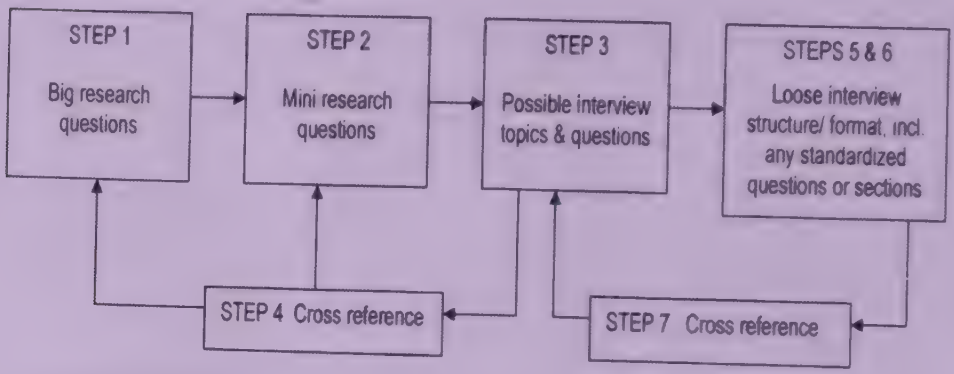
In-depth interviews, unstructured and semi-structured
Like conversations/ no pre-determined response categories

Process: Explore few general topics (to help uncover the participant's meaning perspective)
Approach: Let the participant frame & structure own responses
Focus: on the participant's perspective, not your own
Attitude: Covey an attitude of acceptance that the P's information is valuable & useful
↓ Main Focus: uncover participant's perspective on events, issues, topics
↓ Points to cultivate: Skilful personal interaction – question framing, gentle probing for elaboration; good listening skills; patience</td></tr>
<tr><td>Strengths</td><td>Useful to get large amounts of data quickly
Focus group/ individual interviews
Immediate follow-up & clarifications possible
Combined with observation, ascription of deeper meanings to lifeways</td></tr>
<tr><td>Weaknesses</td><td>Personal interaction: cooperation essential
Interviewee response:
Unwilling & unresponsive
Unaware of recurring patterns in their lives
Misleading/untruthful responses
Interviewer constraints:
Lack of expertise
Familiarity with local language
Ability to comprehend properly</td></tr>
<tr><td>Supplemental data collection techniques</td><td>↓ Narratives
↓ Life Histories
↓ Historical Analysis
↓ Audio and Visual Aids – films, videos & photographs
↓ Questionnaires and Surveys</td></tr>
</table>

PRESENTATION 4: QUALITATIVE INTERVIEWING	
Types of interviews	↓ Informal interview ↓ Unstructured interview ↓ Semi-structured interview ↓ Structured interview with narratives/comments
Informal interview	No structure or control; informal chat Useful in early stages of data collection, where researcher does not have a clear conception of values/patterns of meaning in the local context Intention is to locate oneself in the context and the environment Provides some key information
Unstructured interview	NOT informal discussions; complex process involving special skills Presumes prior agreement between researcher & interviewee over what they plan to do during the interview Researcher minimizes control over respondent. However, clear plan in mind of subtle ways to divulge information over a long period of time Requires a series of interviews with each interviewee Information provided in previous interviews utilized in explorations during subsequent interviews that will thereby become more structured
Semi-structured interview	Use of interview guide - reference to a list of questions/topics as a guide to elicit response Assists the researcher to remember a list of themes/topics for exploration in a particular order Interview guide – informal tool; may either be 'tailor-made' for the specific interview or may be a guide for many interviews Time of interview limited
Structured interview (with narratives/ comments)	Main concept: minimize time of interviewer-interviewee interaction Questions structured to elicit standard quantifiable responses However, respondent may still divulge other useful information Such voluntary information usually explain contextual aspects for/reason behind a given response – added utility
Conducting interviews	
Establishing rapport: Skills of the researcher	Maintain ongoing interview over a relatively long period of time, while focusing on many complex themes Language – framing of questions Interview guide be used only as a referral point – to ensure coverage of broad areas regarding behaviour of physician
Interview setting	Place where both parties are comfortable Relatively calm private location Initial activities: Establishing rapport – mutual respect Indication of (seriousness of) research Taking consent Information about the project – aims & objectives

	Explanation of interest in respondent's knowledge/opinions Assuring openness & freedom to express any answer Assuring confidentiality Interest shown in responses Explanation of approximate expected duration of interview
Asking questions	Choice of words: non-threatening Speech: clarity, audibility Questioning: Non-judgmental (neutrality) Use of alternate phrases Time allowed for response Not to hamper thought process of respondent Types of questions: open/ closed Qualitative research: open questions
Guiding	Responsibility of the interviewer May be called upon to control process by interrupting (at times) & negotiating with respondent Example: *Now you have been describing this to me, but why don't you also describe that aspect as well?*
Probing	Alternate phrasing Examples: silence, gestures, repeating Assists researcher to get respondent to elaborate To revert after a diversion during interview Elicits rich in-depth data Facilitates exploration of new aspects of a theme Maintains continuity of interview process Also useful to indicate agreement & validation
Ending the interview	Refer to process in case respondent wishes to add/ edit/ correct Arrange subsequent appointments, if required Assure confidentiality Usefulness of information Further clarifications
Using a tape recorder	Request permission Negotiate… Test recorder before every interview Watch battery indicators Back-up notes during interview – very important, esp. to capture non-verbal aspects Recording – advantages/ disadvantages

Qualitative Interviews:
Overview of the Planning and Preparation Process



Source: Mason, 1996: 52

PRESENTATION 5: TRANSCRIPTIONS	
What is a transcript?	A transcript or transcription is a word-for-word written copy of a taped interview Allows one to "read" the interview
Why make transcripts?	Aids the researcher to quickly skim & assess the relevance of an interview Saves on wear-and-tear of audiotapes Helps to comprehend voices on the tapes that are difficult to hear/understand Provides, in the case of transcripts submitted on disk, the means to search via computer for specific words and phrases mentioned in the interview
Relationship between transcripts and recording	Original recording & its accompanying transcript - complementary documentation of the same event No matter how thorough and accurate transcripts may be, they are never able to capture all the details in an audio recording such as the tone of voice & emotion expressed in the spoken word, facial expressions & mannerisms Transcripts are, however, excellent access tools They provide an easily accessible reference substitute for the recordings & require no special play-back equipment
How thorough should the transcript be?	The goal is to create a transcript that is both accurate and understandable to the reader Should ideally include every utterance or describe every background noise, but it should reproduce as closely as possible the speaker's words It should also be consistent in the stylistic approach and level of detail throughout
Creating a transcript	↓ Listen to the recording in its entirety once to become familiar with the voices on the tape and the questions being asked. ↓ At the beginning of the transcript, identify who conducted the interview, transcribed the tape, and the date(s) these tasks were done. ↓ When formatting the text on the page, use one inch

	margins on each side of the paper; number the pages; and double-space the text. - Identify all speakers at the start of their comments, by typing their name in bold capital letters, followed by a colon, e.g., SINGH: - Create a verbatim transcript. Include expressions such as "umhum" or "huh-huh" when used to mean "yes" or "no" in response to specific questions. - Place a question mark before and after a word or phrase to indicate any uncertainty about it, e.g., (?destroyed?) - Do not revise the narrator's words to force them into standard written prose. Leave untouched any sentence fragments, run-on sentences, and incorrect grammar - Commas and dashes may be used to reflect pauses in the spoken words - If changes are made, clearly indicate when and how the transcript differs from the original tape recording - Indicate the end of a side of the tape in capital letters, e.g., end of side 1, tape 1; begin side 2, tape 1. - Identify garbled or inaudible portions of the tape. If one word is inaudible, indicate the gap with a ___ . - Put in brackets explanations about why the interview was interrupted or why the tape recorder was turned off, e.g., [Interview interrupted by a telephone call]
Examples from Nvivo: Transcripts from 3 centres: Discussion followed by a practical session	

PRESENTATIONS 6 & 7: NOTE TAKING IN THE FIELD		
In the Field	Field notes - a written account if what the ethnographer has seen, heard & experienced Ethnographers' focus: what the people 'are up to'… Decision of ethnographer: Not just data collection, but also where to go, what to look at, what to ask & say	
Modes of Participation	Mode I - Find out what they 'are up to' - Maximize immersion in local activities - Attend to events with little concern for 'writing it down' - Suspend writing records of these events - Subsequent reflection & examining reflections to produce records	Mode II - Fieldworker concerned with 'getting into place' to observe interesting, significant events - Participation in naturally occurring events explicitly oriented to produce detailed, written records - Positioning in unfolding events in order to observe & write
Strengths and Drawbacks	- Mode I: Experiential style Allows intense immersion in daily rhythms & ordinary concerns, increasing openness in others' ways of life	

	✦ Mode II: Participating-to-write style Produce a more detailed, closer-to-the-moment record of that life *Note: A possible shift from one to the other as events unfold in the field*
Writing Field Notes	In both styles, ethnographer writes field notes contemporaneously with experience, observation of events of interest. Time lag – mode II writing begins earlier Mode II: Writing begins in the field – mental notes, full field notes, written notes (jottings, scratch notes, abbreviated words) Expanded to construct full field notes
Making Jottings	Writing materials Jottings: Key words, phrases; scribble about actions & dialogue; new language - key expressions & terms Functions: Jog the memory about significant actions; enable evocative descriptions of the scene
Where, When and How	Research identity & purpose Tremendous import for relationships in the field Ethical dilemmas: preserving immediacy vs. violations of trust; openness avoids risks & likely sense of betrayal Overt manner of fieldwork – flexibility in when, where & how to jot notes Mutual collaborations & permission Taking out a notebook - familiarity with open writing vs. suspiciousness of note taking Distraction – for both parties Rely upon interactional skills & judgment of situation to decide appropriateness of action Allegations – spying, little familiarity with writing as part of everyday life, intrusive Retreating to private places? Open jotting be carefully calibrated to the unfolding context of the ongoing interaction Strategies change with time spent in the field, as relationships evolve. Suggestions: ✦ Start jottings earlier on, so that if one establishes a 'note-taker' role, jotting notes comes to be part of what people expect from the fieldworker ✦ Offer initial explanations of the need to take notes ✦ Stress importance of accuracy for faithful representation of facts/events ✦ New language: importance of writing down local terms ✦ Note: be tactful, sensitive, avoid/minimize awkward interactions Rule of thumb: no 'best way'; remain open and flexible, ready to alter an approach if it adversely affects people/situations
Participating in order to write: What to observe and write about?	Take note of *initial impressions* Physical environment Locale & the people in it Observe key events or incidents

	Select noteworthy incidents Pay attention to incidents, impressions, interactions (verbal & non-verbal) Use personal reactions effectively Move beyond feelings of sympathy, revulsion Register your feelings, step back & use this experience – do not be judgemental Record as 'significant' or 'important' Jot down details key components of observed scenes & interactions Avoid making statements characterizing what people do – refrain from making generalizations Emphasis – detailed, textured descriptions, NOT evaluative, opinionated words Jot down concrete, sensory details about actions and talk – which *show*, rather than *tell* about people's behaviour Example: Emotional outburst as 'angry words' not enough. Rather, jot down actually spoken words, along with details such as gestures, facial expressions Focus: how others understand & evaluate what happened – do not offer own explanations Jottings as mental notes - signal general impressions, even if you are unsure of its significance at that time. Later – how incidents 'fit together' in meaningful patterns Learn to observe to make notes – details experienced through the senses	
Points to Note	YES • Active verbs • Sensory adjectives • Verbatim exchanges • Respondents' views • Detailed, nuanced descriptions	NO • Passive verbs • Analytic adjectives • Summarized dialogue • Evaluative rendering • Generalized reflections
Writing Up Field Notes	Requires a block of concentrated time In the beginning, advised to leave notes for 2-3 hours to begin full field notes As soon as possible: timing of writing up more crucial than time spent in the field Immediacy of lived experience – fresh, detailed recollections Discussion with others and stale recounting Often burdensome …	
From Field to the Desk *The Process of Writing Up*	Extensive handwritten jottings vs. 'dictated' notes for transcription Ethnographer's stance – adjusting prior views and reorienting vis-à-vis others Ongoing re-socialization Intended/likely audience • Multiple purposes and styles • Recalling in order to write • Turning jottings into full notes • Multiple voices and points of view • 'Real-time' and 'end-point' descriptions	
Discussion of results from practical session against the backdrop of literature handed out		

EXERCISES

Exercise 1: *Observation*

Go to an OPD in the hospital. Sit there for one hour. Write a detailed account of what you observe.

Exercise 2: *Describe an evening with friends.*

- There are two aspects to look at: One is the "time-space" side - a straight forward description of what happened; the other is the more involved side - the personal, emotional, aspect.
- Do not disturb the flow of things by taking notes or playing with a tape recorder. When the get together is over, go straight to your paper and pencil and write down, from memory, what happened. Convert those scribbles into an organized description.

Exercise 3: *Interview person X*

Ask him/her for an hour or two of their time; explain what you are doing and ask their permission to record the interview. Take notes - minimal ones that don't interfere with the flow of the conversation: later, you can sit down by yourself and "fill in the blanks."

You are to pick a topic that might interest both you and your interviewee. Make it a value question; something the person will have an opinion on, something concerning judgements of good and bad.

This is to be an unstructured interview. This means that, although you may interact with the person - ask questions, ask for detail, for clarification, and so on. You should avoid, as much as possible, forcing the person in any direction, other than keeping their attention on the original topic. In other words, back off and let them express themselves.

Summarize the conversation in approximately 6-8 pages, paraphrasing or using the person's own words where they are most effective, using your own words otherwise. Communicate to the prospective reader what the person was expressing. Take great care not to put your ideas into his or her mouth.

Exercise 4: *Transcribe interview recorded on tape.*

To interview each other on given topic, specified for each. The interview is to last approximately 30 minutes. Record interview on tape. Transcribe the interview.

Exercise 5: *Mapping* of Indira Camp using PRA methods

References cited

1. Burgess, R.G. 1984. *In the Field: An Introduction to Field Research*. London: Allen and Unwin (Chapter 2).
2. Emerson, R.M., R. Fretz, and L. Shaw. 1995. *Writing Ethnographic Fieldnotes*. Chicago: University of Chicago Press.
3. Kirk, J. and M Miller. 1986. *Reliability and Validity in Qualitative Research*. Newbury Park, CA: Sage.
4. Kvale, S. 1995. *Interviews*. London & New York: Sage.

5 Mason, J. 1996. *Qualitative Researching*. New Delhi: Sage.
6 Morgan, M. and C. Watkins. 1988. Managing hypertension: Beliefs and responses to medication among cultural groups. *Sociology of Health and Illness*. 10: 561-78.
7 Spradley, J. 1980. *Participant Observation*. New York: Holt, Reinhart & Winston.
8 Stone, L. and J.G. Campbell. 1986. The use and misuse of surveys in international development: An experiment from Nepal. *Human Organization*, 43: 27-37.

AGENDA
TRAINING PROGRAMME
7 – 13 July 2004

DAY 1: 7 July 2004

I	*Introduction of RAs*	*9.30 – 10.00*
II	*Introduction to the Project*	*10.00 – 11.15*
	➢ Review of the protocol	
	➢ Discussion of project objectives	
	➢ Nature of research involved	
	➢ Role of the research assistants	
III	*Status of the Project*	*12.00 – 13.00*
	➢ Progress so far	
	➢ Discussion	
	Lunch Break	*13.00 – 14.00*
IV	*Introduction to Qualitative Research*	*14.00 – 15.00*
	i. Nature of qualitative research	
	➢ Data, sources and methods	
	➢ Entry into the field	
	ii. Qualitative methods – an overview	*15.15 – 15.45*
	Discussion	*15.45 – 17.30*

DAY 2: 8 July 2004

I	*Qualitative Interviewing*	*9.30 – 10.45*
	➢ Logic and rationale vis-à-vis the project	
	➢ Planning, preparation & conducting qualitative interviews	
	➢ Presentation by Co-PI	
	➢ Discussion	
	➢ Practical Exercise	*11.00 – 12.00*
	➢ Critique of exercise	*12.00 - 13.00*
	Lunch Break	*13.00 – 14.00*
II	*Participant Observation*	
	➢ Presentation	*14.00 – 15.00*
	➢ Practical exercise	*15.00 – 16.00*
	➢ Exercise review	*16.15 – 17.30*

DAY 3: 9 July 2004

I	*Writing Field Notes*	
	➢ Note taking in the field: Presentation	*9.30 – 11.00*
	➢ Discussion	
	➢ Practical exercise	*11.15 – 12.00*
	➢ Exercise review and critique of exercise	*12.00 – 13.00*

	Lunch Break	*13.00 – 14.00*
II.	*Field Visits*	*14.00 – 18.00*
	Ambedkar Nagar	
	Indira Camp	

DAY 4: 10 July 2004

On-site Training: *Visit to Midanpuri*	*8.30 – 17.00*
➢ Group interviewing – a discussion	
➢ Transect Walk	
➢ Informal discussions	
➢ Mapping of area (using PRA methods)	

DAY 5: 12 July 2004

I.	*Transcriptions*	
	➢ Presentation	*9.30 – 10.00*
	➢ Practical exercise, followed by discussion	*10.00 – 11.00*
	➢ Review and critique of exercise	*11.15 – 13.00*
	Lunch Break	*13.00 – 14.00*
II.	*Research Ethics*	*14.00 – 15.30*
	➢ Information about the project to participants	
	➢ Confidentiality and protection of data	
	➢ Possible ethical dilemmas in the project – A discussion	
III.	*Review of mapping in Midanpuri*	*15.45 – 16.45*
IV.	*Discussion of background literature*	*16.45 - 17.30*

DAY 6: 13 July 2004

I.	*Discussion of fieldwork*	*9.30 – 10.30*
II.	*Mapping in Indira Camp*	*11.00 – 17.30*

Reference material given to RAs:

Observation:	Spradley, J. 1980. Participant Observation: Steps 1-9
Field Notes:	Emerson, R.M., R. Fretz and L. Shaw. 1995. Writing Ethnographic Fieldnotes: Chapters 2-4
Interviewing:	Kvale, S. 1995. Interviews: Pages 109-251
	Bernard - on probing (printout)

Salient Points of the Study

- The project *Health Systems Reform and Ethics: Private Practitioners in Poor Urban Neighbourhoods in India, Indonesia and Thailand* is a multi-disciplinary multi-country research study on the private health sector in urban poor settlements in south and south-east Asia. The main objective of the project was to identify feasible regulatory mechanisms and strategies for the private healthcare sector to improve quality of care for the urban poor in the country

- In India, the project was carried out during 2004 – 2008 by AIIMS with funding from Danida's research council in Denmark. The report presents the findings of an intensive qualitative/ethnographic study conducted in a large slum of around 25,000 people located in south Delhi.

- The burgeoning 80 million urban poor in India struggle for basic services like housing, water and sanitation. The links between these contextual forces and health outcomes is manifest not only in the striking differentials in health among urban poor and non-poor groups but in health indicators of the urban poor which are comparable to, and in many cases, worse off than, the poor living in rural areas of the country

- Despite the presence of a vast public health network, in the absence of urban primary health care services, the private sector assumes prominence in the health seeking behaviour of the urban poor. The Indian Medical Association estimates that there are 40,000 unregistered medical practitioners in the city who are not trained in any system of medicine, and that there are two 'quacks' for every registered medical practitioner

- In the slum, the local practitioners, a majority of them unlicensed, unregistered practitioners, are the first point if resort

for almost 90% of the respondents. There is an almost exclusive dependence on the less-than-fully-qualified practitioners within the *jhuggi* for basic primary care

- There is widespread ambivalence of the poor towards the government-run facilities. Competence in government facilities was clearly considered higher by the respondents but long distances to these facilities, circuitous and time-consuming registration procedures, rude behaviour of the non-medical staff, indifferent attitude of the doctors and in many cases, bribes that had to be paid to staff in the hospitals were cited as major deterrents

- The ready proximity of the clinics in the settlement, low fees, flexible payment options were considered extremely convenient for wage earners. Besides, these local practitioners considered to "give more attention" in comparison to the government facilities which are too slow and "difficult to deal with"

- In a comparison of prescriptive behaviour patterns between qualified and non-qualified practitioners for fevers (undetermined), cough and cold, diarrhoea, vaginal discharge and tuberculosis - the difference on first consultation was found to be marginal

- Choices that the urban poor make for health care have implications not only for the individuals treated and the development of drug resistance but also for disease transmission to the wider population living in congested urban settings. While their recourse to less-than-fully-qualified practitioners is of urgent concern, their use of qualified private practitioners too needs attention. While the public health consequences of the inappropriate treatment protocols that the less-than-fully-qualified private practitioners use, and their misuse of drugs, is well known, arbitrary prescription practices and delayed

referrals to appropriate facilities by qualified doctors pose serious threats as well

- Unlicensed practitioners very often are the only ones 'on the spot' to provide basic primary care to the approximately 25,000 people inhabiting slum settlements such as Midanpuri. Their piecemeal medication options, as we have seen in the report, are a boon for daily-wage earners; they seem aware of health epidemics and media campaigns around conditions like HIV/AIDS, TB and maternal care; and they clearly appear to treat patients with dignity and respect. What is evident, therefore, is that these less-than-fully-qualified practitioners fill an important gap between the poor perceived quality of public health services and the high cost of the "fully qualified" private health care. Under the circumstances, it could then be argued that they largely succeed in providing at least *some* health care at low cost where none other exists. In the absence of better alternatives, what does the poor person in a slum settlement do?

- The main challenge, therefore, is to bring the informal service providers into the overall public policy net. But since the less-than-fully-qualified practitioners are the 'backbone' of providing health for the urban poor, urgent measures need to be put in place to optimize their presence among congested populations of urban poor who do not have access to any public health interventions by the government. Based on findings from the research study, recommendations have been made by the researchers in the report.

- None of the above will work effectively unless complimentary measures are enforced to confront the local context in the slums. The determinants of slum health are too complex to be defined by any single parameter. Yet, they arise from a common physical and legal derivation that concentrates the ill effects of

poverty, the population composition and dynamics, and the constraints they face because of their marginalization and exclusion from the formal sector. All these underlying social and living conditions are critical pathways to improve health in the slums

Gandhiji's Talisman

I will give you a talisman. Whenever you are in doubt, or when the self becomes too much with you, apply the following test.

Recall the face of the poorest and the weakest man whom you may have seen, and ask yourself, if the step you contemplate is going to be of any use to him. Will he gain anything by it? Will it restore him to a control over his own life and destiny? In other words, will it lead to *swaraj* for the hungry and spiritually starving millions?

Then you will find your doubt and your self melting away.

M.K. Gandhi

AIIMS, New Delhi

CRHSP, Ballabgarh

PHC Chainsa

Sub-centre ShahpurKalan

Comprehensive Rural Health Services Project (CRHSP), Ballabga
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